

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06001

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Buhrman

2. Date of Death

Month

Day

Year

02

23

97

3. Time of Death

4:30am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Meridian Franklin Woods

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

209-12-9944

6. Sex

M 20 F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

7-16-08

9. Birthplace (State or Foreign Country)

pa.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Overlea/Fullerton

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

5 McCormick Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

10 Never Married 20 Married

X0 Widowed 40 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

10 Yes 20 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 yrs.

College (1-4 or 5+)

4 yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Safety Engineer

16b. Kind of Business/Industry

U.S. Army

17. Father's Name (First, Middle, Last)

Samuel Buhrman

18. Mother's Name (First, Middle, Maiden Surname)

Daisy Stouffer

19a. Informant's Name/Relationship (Type, Print)

Mrs. Nancy E. Martin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5 McCormick Avenue Baltimore, Md. 21206

20a. Method of Disposition

X0 Burial 20 Cremation 30 Removal from State

40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cemetery 2-26-97 Baltimore, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lassahn Funeral Home

7401 Belair Rd. Baltimore, Md. 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Congestive Heart Failure

Due to (or as a consequence of):

Approximate interval between Onset and Death

6 months

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Myocardial infarction

Due to (or as a consequence of):

6 months

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Stroke 6 months ago.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

28. Place of Death (Check only one)

Other:

40 Nursing Home

50 Residence

60 Other (Specify)

27. Manner of Death

10 Natural

50 Pending investigation

20 Accident

30 Suicide

40 Homicide

60 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

N. Deshpande MD

29c. License number

D46082

29d. Date signed (Month, Day, Year)

2/23/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NEETA DESHPANDE, M.D. 9200 FRANKLIN SQUARE DR., MD 21237

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

20





97 06002

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |                                |  |   |  |
|---|--|--|--|--|--|--------------------------------|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Lawrence J. Baroch  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 25, 97  |  |                                |  | 3. TIME OF DEATH<br>9:10A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>212-09-1856  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>80 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. FACILITY NAME (If not institution, give street and number)<br>Church Home Retirement Center   |  |  |  | 7b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore   |  |                                |  | 7c. COUNTY OF DEATH<br>N/A  |  |
| 8a. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |  |  | 9a. STATE<br>MD.   |  |                                |  | 9b. COUNTY<br>N/A   |  |
| 10a. STREET AND NUMBER<br>101 N. Bond St. Room 201  |  |  |  | 10b. CITY, TOWN OR LOCATION<br>Baltimore   |  |                                |  | 10c. ZIP CODE<br>21231  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12  |  |                                |  | 16. KIND OF BUSINESS/INDUSTRY<br>Martin-Marietta Manufacturing  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>James L. Baroch  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Uhlik  |  |                                |  | 19. INFORMANT'S NAME (Type/Print)<br>Jerome Baroch/ Brother   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Oak Lawn Cemetery 2/28/97   |  |                                |  | 20c. LOCATION — City or Town, State<br>Baltimore, MD.   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Moran-Ashton Funeral Home, Inc. 21224<br>3000 E. Baltimore St. Balto., MD.   |  |                                |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. END STAGE COPD<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate interval between Onset and Death<br>+ 10 YEARS |  |
| 24. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>CA PROSTATE   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |                                |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  |                                |  | 28b. TIME OF INJURY<br>M  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURED   |  |                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |
| 29c. LICENSE NUMBER<br>D16619   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/25/97   |  |                                |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>C. VERGARA-SOARES 101 N. BOND ST. BALT. MD. 21231  |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 28 1997  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |                                |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760



TO THE HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the Registrar. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item31 see Item32 2-28-97 FilmG744

State of Maryland / Department of Health and Mental Hygiene

97 06003

W.H. Per F/R

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |   |  |
|---|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Evan Carter</b>  |  |   |  | 2. Date of Death<br>Month <b>2</b> Day <b>26</b> Year <b>97</b>  |  | 3. Time of Death<br><b>9:00 AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>2122 Ashton St.</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>N/A</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>250-66-0161</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>54</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>8-9-42</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>S.C.</b>   |  | 10a. State<br><b>md.</b>  |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br><b>2122 Ashton St.</b>  |  |   |  | 10f. Zip Code<br><b>21223</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>N/A</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Dietary Aide</b>  |  | 16b. Kind of Business/Industry<br><b>Sinai Hospital</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Elijah Colter</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Frenchseal Livingston</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Medra Smith daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2122 Ashton St. Baltimore 21223</b>  |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King Mem. Pk</b>   |  | 20c. Date<br><b>3-1-97</b>   |  | 20d. Location - City or Town, State<br><b>Randallstown Md.</b>  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Sela March</b>  |  |   |  | 22. Name and Address of Facility<br><b>March F.H. West<br/>4300 Wabash Avenue Baltimore</b>  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. PROBABLE MYOCARDIAL INFARCTION ON</b><br><b>b. PROBABLE PULMONARY EMBOLISM</b><br><b>c. PROBABLE CEREBRAL HEMORRHAGE</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>d.</b> |  |   |  | Approximate Interval Between Onset and Death   |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><b>Richard W. Huns MD</b>  |  | 29c. License number<br><b>D 13619</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2-27-97</b>   |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Richard W. Huns MD</b>   |  |   |  |  |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br><b>2-27-97</b>   |  | 32. Registrar's Signature<br><b>FEB 28 1997</b>   |  |  |  |   |  |

2 MS 5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06004

Items: 23 part I, 27 per MEO G-746 4/10/97 re **Certificate of Death**

Reg. No.

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>SHERONDA CONAWAY</b>   |   | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 21, 1997</b>  |   | 3. Time of Death<br><b>1:56 P.</b>   |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>1700 ARGONNE DR.</b>   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |   | 4c. County of Death<br><b>BALTIMORE</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-13-9731</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>20</b> Yrs.  | If Under 1 Year<br>Months Days                                  | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>3/28/76</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Wash. D.C.</b>   |   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |   | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>P.G.</b>   |
|   | 10c. City, Town or Location<br><b>Ft. Washington</b>  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |
|   | 10e. Street and Number<br><b>7200 Jaywick AVE. #300</b>   |   | 10f. Zip Code<br><b>20744</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>2</b>                        |   |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Student</b>   |   | 16b. Kind of Business/Industry<br><b>Morgan State</b>   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Ernest Conaway</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sonora Brown</b>  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Sonora Conaway</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7200 Jaywick Ave. #300 Ft. Wash. MD. 20744</b>    |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Old Field Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>2/26/97 Millsboro, Delaware</b>  |
|   | 21. Signature of Funeral Service Licensee<br><i>James Edwards</i>   |   | 22. Name and Address of Facility<br><b>Hodges and Edwards<br/>3910 Silver Hill RD. Suitland, Md 20746</b>   |   |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>MENINGOCOCCAL SEPTICEMIA</b>    |   |   |   | Approximate Interval Between Onset and Death   |
|   | Due to (or as a consequence of):  |   |   |   |  |
|   | Due to (or as a consequence of):  |   |   |   |  |
|   | Due to (or as a consequence of):  |   |   |   |  |
|   | Due to (or as a consequence of):  |   |   |   |  |
|   | Due to (or as a consequence of):  |   |   |   |  |
|   | Due to (or as a consequence of):  |   |   |   |  |
|   | Due to (or as a consequence of):  |   |   |   |  |
|   | Due to (or as a consequence of):  |   |   |   |  |
|   | Due to (or as a consequence of):  |   |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |   |   |   |   |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>                                 |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 28d. Describe how injury occurred   |   |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |   |  |
| 29b. Signature and title of certifier<br><i>David R. Fowler</i>   |   | 29c. License number<br><b>OCME</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 22, 1997</b> |  |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>David R. Fowler 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>   |   |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 28 1997</b>   |   | 32. Registrar's Signature<br><i>J. Davidson-Randall</i>   |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Margaret Crawford</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb. 24 1997</b>   |  | 3. TIME OF DEATH<br><b>11:10 a M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577-18-6842</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Mar. 19, 1921</b>                                  |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>Maria Health Center 6401 N. Charles St.</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>6401 N. Charles St.</b>   |  |   |  | 10f. ZIP CODE<br><b>21212</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify <b>White</b>                          |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>teacher</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Parochial Schools</b>                                      |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Bernard Crawford</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ruth Marie Louis</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Bernice Feilinger SSND</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6401 N. Charles St. Balto. MD 21212</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Villa Maria Cemetery 2/27</b>   |  | 20c. LOCATION — City or Town, State<br><b>Glen Arm, MD</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Donnis Stephen Kenake</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Mitchell Wiedefeld Home 6500 York Rd. 21212</b>  |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>A1ZHeimers disease</b>  |  |   |  |   |  |   |  |
| Sequitentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |   |  |   |  |   |  |
| a. DUE TO (OR AS A CONSEQUENCE OF): <b>Age</b>   |  |   |  |   |  |   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>A SCUD CAROTID Artery Stenosis</b><br><b>Seizure disorder</b>   |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURED   |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J. Boas</i>  |  |   |  | 29c. LICENSE NUMBER<br><b>D15871 MD.</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/26/97</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Lawrence Boas MD 54 Scott Adam Rd. Cockeysville MD 21030</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 28 1997</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06006

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCIS

DENNIS

2. Date of Death

February 27 1997

3. Time of Death

4:00 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Stella Maris at Mercy

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

217-14-9458

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

4-7-20

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10e. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

524 N. Charles St.

10f. Zip Code

21201

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

Alisa Kobrinetz-Guardian 5 South Light St. Baltimore MD 21202

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

MT. Zion Cemetery 1/7/97 Lansdowne MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. Zion Cemetery 1/7/97 Lansdowne MD

Date

1/7/97

20c. Location - City or Town, State

Lansdowne MD

21. Signature of Funeral Service Licensee

Albert P. Wyllie

22. Name and Address of Facility

Albert P. Wyllie FTH, PA  
638 N. Gilman St. Baltimore MD 21207

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.

Immediate Cause (Final disease or condition resulting in death)

e. METASTATIC ADENOCARCINOMA OF UNKNOWN PRIMARY MAMMARY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) STELLA MARIS AT MERCY

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. J. J. J.

29c. License number

D40480

29d. Date signed (Month, Day, Year)

February 27, 1997

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

FERNANDO J. FERRO, MD

5810 BELAIR RD.  
BALTO., MD 21206

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

Julia Davidson-Rendell

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked "natural", or items 23a or 28a-4 show any injury or other traumatic cause, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06007

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GILBERT KENNETH DOXZON

2. Date of Death

Month Day Year

FEBRUARY 24 1997

3. Time of Death

1205AM

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

216-07-6379

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 14, 1917

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

PARKVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

86 Cedar Chip Court

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

I

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Sheet Metal Estimator

16b. Kind of Business/Industry

Sheet Metal

17. Father's Name (First, Middle, Last)

Isaach Jacob Doxzon

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Boettinger

19a. Informant's Name/Relationship (Type, Print)

Bessie L. Doxzon/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

86 Cedar Chip Ct., Balto., MD 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mausoleum

Date

26 FEB

20c. Location - City or Town, State

1997 Timonium MD

21. Signature of Funeral Service Licensee

Bryan W. Clary

22. Name and Address of Facility

Lemmon Funeral Home of Dulaney Valley, Inc.

10 W. Padonia Rd., Timonium, MD 21093

23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

end-stage chronic obstructive lung disease years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

None

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Anthony Kelly

29c. License number

D25205

29d. Date signed (Month, Day, Year)

February 24, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

W. A. Riley GBMC 6701 N. Charles St. Balto., md.

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

John Davidson

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-1234.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06008

## Certificate of Death

Reg. No.

|   |   |  |   |                               |  |  |   |  |
|---|---|--|---|-------------------------------|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Dominick J. DiAngelo</b>   |  |   |                               | 2. Date of Death<br>Month Day Year<br><b>February 19 1997</b>  |  | 3. Time of Death<br><b>11:00 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Genesis ElderCare Perring Parkway</b>  |  |   |                               | 4b. City, Town, or Location of Death<br><b>Parkville</b>   |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>215-07-5573</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |                               | 7. Age (In yrs. last birthday)<br><b>95</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug 28, 1901</b>                                  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10e. State<br><b>Maryland</b>   |                               | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Parkville</b>   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent<br><b>2913 Topaz Rd.</b>  |  |   |                               | 10f. Zip Code<br><b>21234</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4 yrs.</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Department Recreation</b>   |                               | 16b. Kind of Business/Industry<br><b>Baltimore City</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Anthony DiAngelo</b>  |  |   |                               | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Theresa UNKNOWN</b>  |  |   |  |
|   | 19e. Informant's Name/Relationship (Type, Print)<br><b>Joseph DiAngelo / son</b>  |  |   |                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2913 Topaz Rd. Parkville, Maryland 21234</b>   |  |   |  |
|   | 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory, or other place)<br><b>Gardens of Faith</b>  |                               | 20c. Location - City or Town, State<br><b>Rosedale, Maryland</b>   |  | 20d. Date<br><b>Feb. 22 1997</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |                               | 22. Name and Address of Facility<br><b>Evans Chapel of Memories 8800 Harford Rd. Parkville, Md 21234</b>   |  |   |  |
|   | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Pneumonia</b>   |  |   |                               |  |  |   |  |
|   | 23f. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Arterio-sclerotic Cardiovascular disease</b>  |  |   |                               |  |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |                               |  |  |   |  |
| 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |                               |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |                               |  |  |   |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>In the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.<br>Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                               |  |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28e. Date of Injury (Month, Day, Year)  |                               | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 28d. Describe how Injury occurred   |                               |  |  |   |  |
|   | 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |                               |  |  |   |  |
| State Registrar   | 29b. Signature and title of certifier<br>   |  |   |                               | 29c. License number<br><b>008358</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>February 20, 1997</b>                             |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Bracilio Patricio 8903 Harford Rd. Parkville, Md 21234</b>   |  |   |                               |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 28 1997</b>   |   |  |   | 32. Registrar's Signature<br> |  |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06009

|   |   |  |   |   |  |
|---|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Margaret Edmond</b>  |  | 2. Date of Death<br>Month <b>Feb</b> Day <b>27</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>5:50 AM</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Deaton Hospital Center</b>   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |   | 4c. County of Death<br><b>Na</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-38-8065</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                   | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.  | If Under 1 Year<br>Months Days                        | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>03-10-15</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>VA</b>   |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>NA</b>  |   | 10c. City, Town or Location<br><b>Baltimore</b>  |
|   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   |  |
|   | 10e. Street and Number<br><b>600 South Charles Street</b>   |  | 10f. Zip Code<br><b>21230</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |   |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Unknown</b><br>College (1-4 or 5+) <b>NA</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>                         |   | 16b. Kind of Business/Industry<br><b>various trades</b>  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Ed Burger</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Malinda calloway</b>  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Deloris Hollowell</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1020 S. Charles Street Baltimore, Md. 21230</b> |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>  |   | 20c. Date<br><b>03-03-97</b>   |
|   | 20d. Location - City or Town, State<br><b>Woodlawn, Md.</b>   |  |   |   |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   | 22. Name and Address of Facility<br><b>Baltimore, Md 21202</b><br><b>WM.C. March FH 1101 E. North Avenue</b> |   |   |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                             |  |   |   | Approximate Interval Between Onset and Death   |
|   | Immediate Cause (Final disease or condition resulting in death)<br><b>a. acute myocardial infarction suspected</b>  |  |   |   | <b>(on line)</b>   |
|   | Due to (or as a consequence of):<br><b>b. Atherosclerotic heart disease</b>   |  |   |   | <b>10 yrs</b>  |
|   | Due to (or as a consequence of):<br><b>c. Congestive heart failure</b>  |  |   |   | <b>5 yrs</b>   |
|   | Due to (or as a consequence of):<br><b>d. peripheral arterial disease</b>   |  |   |   |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>left leg osteomyelitis. Chronic renal insufficiency</b>  |  |   |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                      |  |   |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)<br><b>M</b>   |   | 28b. Time of Injury<br><b>1</b> Yes <b>2</b> No       |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred  |   |   |  |
| 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                 |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |   |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |   | 29c. License number<br><b>D 30494</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>2/27/97</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>K. Deaton 4060 Wilkerson Ave Baltimore MD 21227</b>  |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 28 1997</b>   |   | 32. Registrar's Signature<br><i>[Signature]</i>  |   |   |  |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be furnished for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06010

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MAE E. FARRELL

2. Date of Death

February 26 1997

3. Time of Death

9:45 PM

4e. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

236-24-0477

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

January 31, 1914

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2916 Hillcrest Avenue

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Unknown

College (14 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Lundy

Miller

18. Mother's Name (First, Middle, Maiden Surname)

Lucy

McMillion

19e. Informant's Name/Relationship (Type, Print)

Mr. Charles Mackey - Brother in law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8106 Harris Ave. Baltimore, Maryland 21234

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Memorial

Date

3/3/97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee Paul L. Hartsock, Jr.

Paul L. Hartsock, Jr.

22. Name and Address of Facility

Leonard J. Ruck, Inc. 5305 Harford Rd. Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 days.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Pneumonia

7 days.

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Ischemia

Gastrointestinal Bleed

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. A. Wadawa

29c. License number

D48268

29d. Date signed (Month, Day, Year)

February 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KALYAN WADWA, MD

Good Samaritan Hospital, Baltimore

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

John Davidson-Randall

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Alternate Designated: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



97 06011

Item 6.7 per FH Film G744 2-28-97 via

1 - STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ANN J. FLANIK</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>FEB</b> DAY <b>25</b> YEAR <b>1997</b>   |  | 3. TIME OF DEATH<br><b>12:30 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>295-09-1659</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year) <b>13</b><br><b>3-29-12</b>                              |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>CANTON Harbor Healthcare</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE, MD</b>   |  | 9c. COUNTY OF DEATH<br><b>N/A</b>   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>RANDALLSTOWN</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>3935 TIVERTON ROAD</b>   |  |  |  | 10f. ZIP CODE<br><b>21133</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b></b>  |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>  |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>CHARLES MANAK</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARIE MRNAK</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CAROLE WAGGONER, DAUGHTER</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3935 TIVERTON RD. RANDALLSTOWN, MD. 21133</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>HOLY CROSS CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>2-28 CLEVELAND, OH</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Philip Starks</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>STERLING ASHTON FUNERAL HOME, INC.<br/>736 EDMONDSON AVE., BALT., MD 21228</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ADVANCED ALZHEIMER'S DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate interval Between Onset and Death <b>YEARS</b> |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|   |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>C. Vergara-Soares MD</b>   |  | 29c. LICENSE NUMBER<br><b>D16619</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/25/97</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>C. VERGARA-SOARES 100 N. BROADWAY ST. BALT. MD. 21231</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 28 1997</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06012

## Certificate of Death

Reg. No.

|   |   |  |  |   |  |                                |   |  |
|---|---|--|--|---|--|--------------------------------|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>EDNA M. GLUTH</b>  |  |  |   | 2. Date of Death<br>Month Day Year<br><b>FEB. 26, 1997</b>   |                                | 3. Time of Death<br><b>1:05 pm</b>                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>INNS OF EVERGREEN NURSING HOME</b>   |  |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |                                | 4c. County of Death<br><b>N/A</b>                                       |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>215-01-8388</b>   |  | 6. Sex<br><b>1 M 2 F</b>   | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>April 16, 1911</b>            |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  |  |   |  |                                |   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  |  |   | 10a. State<br><b>MD</b>  |                                | 10b. County<br><b>N/A</b>   |  |
|   | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  |  |   | 10d. Inside City Limits<br><b>1 X Yes 2 No</b>   |                                |   |  |
|   | 10e. Street and Number<br><b>2525 W. BELVEDERE AVE</b>  |  |  |   | 10f. Zip Code<br><b>21215</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
|   | 11. Marital Status<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b>   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No Specify:</b>   |                                | 14. Race - American Indian, Black, White, etc.<br><b>Specify: WHITE</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) N/A</b>   |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEWIFE</b> |   | 16b. Kind of Business/Industry<br><b>Home</b>  |                                |   |  |
| To Be Completed by Physician/Medical Examiner   | 17. Father's Name (First, Middle, Last)<br><b>FRANCIS COUFAL</b>  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FRANCES HROMADNIK</b>  |                                |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. William C. GLUTH</b>   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2625 CANTERBURY RD. BALTO, MD. 21234</b> |                                |   |  |
|   | 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holy Redeemer Cem.</b>                          |   | 20c. Location - City or Town, State<br><b>BALTO, MD.</b>   |                                | 20d. Date<br><b>3/1</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |  |   | 22. Name and Address of Facility<br><b>HARTLEY MILLER FUNERAL HOME<br/>7527 HARFORD RD. BALTO, MD. 21234</b>                                 |                                |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>(Peripheral vascular disease)<br/>Infected leg ulcers</b> |  |  |   | Approximate Interval Between Onset and Death   |                                |   |  |
| Immediate Cause (Final disease or condition resulting in death)<br>Due to (or as a consequence of):<br><b>diabetes mellitus</b><br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):   |   |  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b> |  |                                |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>  |   |  |  | 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>   |  |                                |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><b>N/A</b>   |   |  |  | 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>   |  |                                |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 8 Other (Specify)</b>  |   |  |  | 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicida 4 Homicide 5 Pending Investigation 6 Could not be determined</b>                     |  |                                |   |  |
| 28a. Date of Injury (Month, Day Year)<br><b>N/A</b>   |   |  |  | 28b. Time of Injury<br><b>M</b>   |  |                                |   |  |
| 28c. Injury at Work?<br><b>1 Yes 2 No</b>   |   |  |  | 28d. Describe how Injury occurred   |  |                                |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |                                |   |  |
| 29a. Certifier (Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |   |  |  | 29b. Signature and title of certifier<br><b>Deborah Morris MD</b>   |  |                                |   |  |
| 29c. License number<br><b>D31364</b>  |   |  |  | 29d. Date signed (Month, Day, Year)<br><b>2/28/97</b>   |  |                                |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>21 Crossroads Dr., Owings Mills MD 21117</b>   |   |  |  | 31. Date filed (Month, Day, Year)<br><b>FEB 28 1997</b>   |  |                                |   |  |
| 32. Registrar's Signature<br><b>John Davidson-Randall</b>   |   |  |  |   |  |                                |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06013

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RAE GUERRERO

2. Date of Death

Month Day Year  
FEBRUARY 26, 1997 4:45 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare Homewood Center BALTIMORE

4b. City, Town, or Location of Death

BALTIMORE CITY

5. Social Security Number

212-18-9909

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month) Day Year  
Sept. 15, 1918 Maryland

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inade City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6000 Bellona Ave.

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African American

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Domestic Child Care Worker

16b. Kind of Business/Industry

Private Family

17. Father's Name (First, Middle, Last)

Horace Stokes

18. Mother's Name (First, Middle, Maiden Surname)

Martha Veney

19a. Informant's Name/Relationship (Type, Print)

Mr. Lee Crump (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1806 Brunt St. Balto. Md. 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus

Date

3/5/97

20c. Location - City or Town, State

Balto. Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home  
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IMMEDIATE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. [Signature]

29c. License number

D1840

29d. Date signed (Month, Day, Year)

FEBRUARY 26, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

IAN SUNSHINE MD 6710 PARK HEIGHTS AVE, BALTIMORE MD 21205

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be attached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 06014

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BENJAMIN GOLDSTEIN

2. Date of Death

February 12, 1997

3. Time of Death

4:44 AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

103-07-9262

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 12, 1911

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10120 New Hampshire Avenue, Apt. 303

10f. Zip Code

20903

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Laundry

17. Father's Name (First, Middle, Last)

Israel Goldstein

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Goldberg

19a. Informant's Name/Relationship (Type, Print)

Iris B. Rose, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22412-2 Jeffrey Mark Court  
Chatsworth, California 91311

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

2/14/1997

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licenses

Donald C. Stottmeyer

22. Name and Address of Facility

STEIN HEBREW MEMORIAL FUNERAL HOME, INC.

232 CARROLL STREET, N.W., WASHINGTON, D.C. 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Renal Cell Cancer

Approximate Interval Between Onset and Death

One year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

Coronary heart failure

many years

b. Due to (or as a consequence of):

Anemia of Chronic disease

many years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Chahid Ahmed

29c. License number

D43496

29d. Date signed (Month, Day, Year)

February 12 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MOHAMMAD A. KHARID MD. 8830 Cameron Court Suite 502 Silver Spring

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

Julia Davidson-Rodriguez

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the report deals with the general situation of the country and the progress of the work during the year.

2. The second part of the report deals with the results of the work during the year and the progress of the work during the year.

3. The third part of the report deals with the results of the work during the year and the progress of the work during the year.

4. The fourth part of the report deals with the results of the work during the year and the progress of the work during the year.

5. The fifth part of the report deals with the results of the work during the year and the progress of the work during the year.

6. The sixth part of the report deals with the results of the work during the year and the progress of the work during the year.

7. The seventh part of the report deals with the results of the work during the year and the progress of the work during the year.

8. The eighth part of the report deals with the results of the work during the year and the progress of the work during the year.

9. The ninth part of the report deals with the results of the work during the year and the progress of the work during the year.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06015

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Doris G. Gavin

2. Date of Death

February 24, 1997 5:00PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

807 Edmondson Ave.

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

213-09-9677

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

02/22/1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

807 Edmondson Ave.

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Federal Gov't.

17. Father's Name (First, Middle, Last)

Thomas Joseph Getzendanner, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Rose Marie Friede

19a. Informant's Name/Relationship (Type, Print)

Cecilia Ludwig/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

606 Worcester Rd. Towson, MD. 21286

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)


Lorraine Park Cem.

Date

2/28/97 Woodlawn, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Sterling Ashton Funeral Home, Inc.

736 Edmondson Ave. Balto., MD. 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Immediate

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D23365

29d. Date signed (Month, Day, Year)

2/26/97

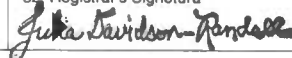
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patrick W. White 716 Maiden Choice Lane, Baltimore, MD 21228

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature


State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06016

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET POLHOUSE GERMIDA

2. Date of Death

Month Day Year  
FEB 21, 1997

3. Time of Death

5:30 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

18 WYNDCREST ROAD

4b. City, Town, or Location of Death

CATONSVILLE

4c. County of Death

BALTIMORE

5. Social Security Number

219-40-5394

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JUL 28 1942

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

CATONSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18 WYNDCREST ROAD

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

CRYPTOLOGIST

16b. Kind of Business/Industry

FEDERAL  
GOVERNMENT

17. Father's Name (First, Middle, Last)

BERNARD POLHOUSE

18. Mother's Name (First, Middle, Maiden Surname)

MARGARET HUGHS

19a. Informant's Name/Relationship (Type, Print)

FRANCIS M. GERMIDA, HUSB.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18 WYNDCREST RD., BALT., MD 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

GLEN HAVEN CEMETERY 2-25

Date

20c. Location - City or Town, State

GLEN BURNIE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

STERLING ASHTON FUNERAL HOME, INC.  
736 EDMONDSON AVE., BALT., MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. ANAPLASTIC ASTROCYTOMA

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

10 MONTHS

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

023683

29d. Date signed (Month, Day, Year)

MAR. FEB 24, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THE JOHNS HOPKINS ONCOLOGY CENTER, BALTIMORE, MD

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital and attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

97 06017

Reg. No.

|  |   |  |   |   |  |                                |  |  |  |  |
|--|---|--|---|---|--|--------------------------------|--|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>Benjamin Hammond  |  |   |   | 2. Date of Death<br>Month 2 Day 5 Year 1997  |                                | 3. Time of Death<br>21:47 PM   |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Ft. Washington Hospital   |  |   |   | 4b. City, Town, or Location of Death<br>Fort Washington  |                                | 4c. County of Death<br>Prince Georges  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>579-16-6145  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>73 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br>6-11-1923   |  | 9. Birthplace (State or Foreign Country)<br>Washington, D.C. |  |
|  | Usual Residence of Decedent   |  |   |   |  |                                |  |  |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br>D.C.  |  | 10b. County<br>NA   |   | 10c. City, Town or Location<br>Washington  |                                |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
|  | 10e. Street and Number<br>3301 Whitlock, SE   |  |   |   | 10f. Zip Code<br>20032   |                                | 10g. Citizen of What Country?<br>U S A   |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK   |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th Grade<br>College (1-4or 5+)   |  |   | 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Fork Lift Driver |  |                                | 16b. Kind of Business/Industry<br>Private  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Benjamin Hammond, Sr.  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Eleanor Johnson   |                                |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Frances Hammond   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3301 Whitlock, SE / Washington, D. C. 20032   |                                |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Lincoln Memorial                                    |  | Date<br>2-27-97                |  | 20c. Location - City or Town, State<br>Suitland, MD  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Shelly Bice</i>   |  |   |   | 22. Name and Address of Facility<br>Robert G. Mason Funeral Home<br>1661 Goodhope RD., SE - Washington, DC 20020   |                                |  |  |  |  |
|  | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. MULTIPLE INJURIES<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d.       |  |   |   |  |                                |  |  |  | Approximate Interval Between Onset and Death |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br><br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |   |   |  |                                |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |                                |  |  |  |  |
|  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)<br>2 - 5 - 97  |   | 28b. Time of injury<br>21:05 PM  |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                |  | 28d. Describe how injury occurred<br>Pedestrian stuck by car |  |
|  |   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br>Roadway   |   |  |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>RT 210/ 495 Prince Georges Co. |  |  |  |
|  | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><i>Margarita Korell</i>  |   | 29c. License number<br>O.C.M.E.  |                                | 29d. Date signed (Month, Day, Year)<br>FEBUARY 05, 1997  |  |  |  |
| State Registrar  | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br>Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201  |  |   |   |  |                                |  |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br>FEB 28 1997  |  | 32. Registrar's Signature<br><i>John Davidson-Randall</i>   |   |  |                                |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

3  
E





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06018

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DORIS HALL

2. Date of Death

Month Day Year  
February 25 1997

3. Time of Death

4:30 PM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Ctr.

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

212-20-3481

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 4, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2515 Gray Manor Terrace

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Frank J. Waltman

18. Mother's Name (First, Middle, Maiden Surname)

Sadie C. Mooney

19a. Informant's Name/Relationship (Type, Print)

Mr. Joseph E. Hall, Sr./Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2515 Gray Manor Terrace Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parkwood Cemetery 2/27/1997

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave. Dundalk, Maryland 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Hepatic Encephalopathy

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 days

b.

Cirrhosis

Due to (or as a consequence of):

3 years

c.

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D48193

29d. Date signed (Month, Day, Year)

February 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David P. Stornelli, M.D. Johns Hopkins Bayview Med. Ctr. Baltimore, MD 21224

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed  
within 24 hours after death.  
To the Hospital or Attending Physician: This certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06019

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EARLE ALFRED HORINE

2. Date of Death

FEBRUARY 26, 1997 18:00 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

1015 CHERRYTOWN ROAD

4b. City, Town, or Location of Death

WESTMINSTER

4c. County of Death

CARROLL

5. Social Security Number

220-14-6017

6. Sex

M 2 F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Oct. 4, 1924

9. Birthplace (State or Foreign Country)

Frederick, Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

1015 Cherrytown Road

10f. Zip Code

21158

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates: WW2

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9th grade

College (1-4or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

C.S.X. Railroad

16b. Kind of Business/Industry

Clerk

17. Father's Name (First, Middle, Last)

George Horine

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Rook

19a. Informant's Name/Relationship (Type, Print)

Mrs. Dorothy L. Horine (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1015 Cherrytown Road Westminster, Md. 21158

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Myersville Cemetery

Date

3/2/97

20c. Location - City or Town, State

Myersville, Md.

21. Signature of Funeral Service Licensee

*Sam B. Elmer*

22. Name and Address of Facility

11824 Reisterstown Road  
ELINE FUNERAL HOME Reisterstown, Md. 21136

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

*Hypertensive Arteriosclerotic Cardiovascular Disease*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Epilepsy*

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Inspection

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending Investigation

6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Theodore M. King*

29c. License number

OCME

29d. Date signed (Month, Day, Year)

FEBRUARY 27, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

*Theodore M. King*

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

*Richardson-Randall*State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06020

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JERRY JACKSON

2. Date of Death

February 26 1997

3. Time of Death

1530

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

214-50-0843

6. Sex

X M 2 F

7. Age (In yrs. last birthday)

49

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11-15-47

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

2508 Huron Street

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 X Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

1 Yes 2 X No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th GradeCollege (1-4 or 5+)  
Na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Warehouse personal

16b. Kind of Business/Industry

Hecht Company

17. Father's Name (First, Middle, Last)

John Jackson

18. Mother's Name (First, Middle, Maiden Surname)

Susie Fisher

19a. Informant's Name/Relationship (Type, Print)

Susie Fisher Jackson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2508 Huron Street Baltimore, Md. 21230

20a. Method of Disposition

1 X Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery 03-01-97 Lansdowne, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensed

22. Name and Address of Facility

Baltimore, Maryland

WM.C.March FH 1101 E. North Avenue 21202

23a. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

EXTENSIVE BILATERAL

a. PNEUMOCOCCAL PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 DAYS

b. PNEUMOCOCCAL SEPTICEMIA

Due to (or as a consequence of):

1 WEEK

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALCOHOL ABUSE

SUPERVENTRICULAR TACHYCARDIA

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed?

1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 X No

25. Was case referred to medical examiner?

1 Yes 2 X No

Hospital:

1 X Inpatient

2 ER/Outpatient

3 DOA

26. Place of Death (Check only one)

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 X Natural 5 Pending investigation  
2 Accident 6 Could not be determined  
3 Suicide  
4 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Anthony P. Dasano

29c. License number

AS2441614-50

29d. Date signed (Month, Day, Year)

February 26, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ANTHONY P. DASANO

3001 SOUTH HANOVER STREET

BALTIMORE MARYLAND

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: A funeral certificate has been signed by the attending physician and completely filled in by the funeral director. Page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

February 20, 1975

REPLY

Reference

Internal Security Matter

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

10 days  
1 week

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION

February 20, 1975  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06021

Reg. No.

|   |  |   |   |  |  |  |   |                                   |  |
|---|--|---|---|--|--|--|---|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Frank Kober</b>   |   |   |  | 2. Date of Death<br>Month <b>Feb</b> Day <b>25</b> Year <b>97</b>  |  | 3. Time of Death<br><b>2211</b>   |                                   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Sinai Hospital</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>N/A</b>                                       |                                   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-05-2438</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>August 28, 1907</b>           |                                   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   |   |  |  |  |   |                                   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |                                   |  |
|   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |   |                                   |  |
|   | 10e. Street and Number<br><b>4601 Pall Mall Road</b>   |   |   |  | 10f. Zip Code<br><b>21215</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |                                   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4 years</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Owner</b>                         |  | 16b. Kind of Business/Industry<br><b>Bar</b>   |  |   |                                   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Frank Kober</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Julia Brunner</b>  |  |   |                                   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Caroline Stack (Daughter)</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8009 Edgewater Avenue, Baltimore, Maryland 21237</b>                                     |  |   |                                   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Green Mount Crematory</b>  |  | Date<br><b>2-28</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>       |                                   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>  |   |   |  | 22. Name and Address of Facility<br><b>Schimunek Funeral Home<br/>3331 Brehms Lane, Baltimore, Maryland 21213</b>  |  |   |                                   |  |
|   | 23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Myocardial Infarction</b><br>Due to (or as a consequence of):<br><b>Coronary artery Disease</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>COPD</b><br><b>Dementia</b> |   |   |  | Approximate Interval Between Onset and Death   |  |   |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>COPD</b><br><b>Dementia</b>  |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |                                   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |  |   |                                   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |   |                                   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   | 28d. Describe how Injury occurred |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>[Signature]</b>   |   | 29c. License number<br><b>035330</b>             |  | 29d. Date signed (Month, Day, Year)<br><b>2/25/97</b>  |   |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sinai Hospital, 2401 West Belvedere Avenue, Baltimore, Maryland 21215</b>  |  |   |   |  |  |  |   |                                   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 28 1997</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |  |  |   |                                   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The information on this death certificate is to be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been filed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06022

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DONALD A. KLEIN

2. Date of Death

February 25 1997

3. Time of Death

100PM

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

214-30-5376

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 30, 1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1021 Shoreland Drive

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates: Viet Nam

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Union Local 101

17. Father's Name (First, Middle, Last)

John Jefferson Klein

18. Mother's Name (First, Middle, Maiden Surname)

Mary Elizabeth Hoffman

19a. Informant's Name/Relationship (Type, Print)

Shirley Cross ( Sister )

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1021 Shoreland Drive Glen Burnie, MD. 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Memorial Park

Date

2/27/97

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

Kevin E. Ecker

22. Name and Address of Facility

McCully Funeral Home of Brooklyn  
237 E. Patapsco Ave. Balto., MD. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Approximate Interval Between Onset and Death

2 weeks

Due to (or as a consequence of):

b. CONGESTIVE HEART FAILURE

2 weeks

Due to (or as a consequence of):

c. SEPTIC SHOCK

2 weeks

Due to (or as a consequence of):

d. PULMONARY EDEMA

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dan H. Schaefer, MD

29c. License number

028221

29d. Date signed (Month, Day, Year)

February 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEL SCHAEFER, MD 301 HOSPITAL DRIVE GLEN BURNIE MARYLAND

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

John Jefferson Klein

21061

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours of death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06023

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Eugene Kaplan

2. Date of Death

Month  
02Day  
21Year  
97

3. Time of Death

08<sup>55</sup> AM

4a. Facility Name (If not institution, give street and number)

LAUREL REGIONAL HOSPITAL

4b. City, Town, or Location of Death

LAUREL

4c. County of Death

PG

Funeral  
Director

5. Social Security Number

122 18 0908

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

68

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

AUG. 31, 1928

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGES

10c. City, Town or Location

LAUREL

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

8795 OXWELL LANE

10f. Zip Code

20708

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Navar Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

KOREA

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SENIOR TRIAL ATTORNEY

16b. Kind of Business/Industry

FEDERAL TRADE COMM.

17. Father's Name (First, Middle, Last)

CHARLES KAPLAN

18. Mother's Name (First, Middle, Maiden Surname)

BERTHA BERKUN

19a. Informant's Name/Relationship (Type, Print)

VALERIE JO KAPLAN/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS ITEM 10a-10f

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. LEBANON CEMETERY

Date

2/23/97

20c. Location - City or Town, State

ADELPHI, MARYLAND

21. Signature of Funeral Service Licensee

Peter J. Hansen

22. Name and Address of Facility

IVES-PEARSON FUNERAL HOMES

472 N. WASHINGTON ST. FALLS CHURCH, VA. 22046

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. Ischemic Cardiomyopathy

Due to (or as a consequence of):

c. Urrosepsis

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

7 hours

7 years

1 week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicida 4 ☐ Homicida

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John Marselis MD

29c. License number

D25430

29d. Date signed (Month, Day, Year)

02/21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Marselis, MD 14333 Laurel-Bowie Rd #307 Laurel, MD 20708

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the Burial-Transit

20



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06024

## Certificate of Death

Reg. No.

|  |   |  |  |  |   |  |  |  |   |  |
|--|---|--|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><i>Richard Lee</i>  |  |  |  | 2. Date of Death<br>Month <i>February</i> Day <i>24</i> Year <i>1997</i>  |  |  |  | 3. Time of Death<br><i>6:46 AM</i>  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><i>Northwest Hospital 5401 Old Court Road</i>   |  |  |  | 4b. City, Town, or Location of Death<br><i>Randallstown 21133</i>   |  |  |  | 4c. County of Death<br><i>Baltimore County</i>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>241-48-1247</i>   |  | 6. Sex<br><i>1</i> M <i>2</i> F  |  | 7. Age (In yrs. last birthday)<br><i>61</i> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><i>Feb. 8, 1936</i>                   |  | 9. Birthplace (State or Foreign Country)<br><i>N.C.</i>   |  |
|  | Usual Residence of Decedent   |  |  |  |   |  |  |  |   |  |
| To Be Completed by Funeral Director                                  | 10a. State<br><i>md</i>   |  | 10b. County<br><i>N/A</i>  |  | 10c. City, Town or Location<br><i>Baltimore</i>   |  |  |  | 10d. Inside City Limits<br><i>1</i> Yes <i>2</i> No   |  |
|  | 10e. Street and Number<br><i>2819 Ruscombe Lane</i>   |  |  |  | 10f. Zip Code<br><i>21215</i>   |  | 10g. Citizen of What Country?<br><i>USA</i>                                  |  |   |  |
|  | 11. Marital Status<br><i>2</i> Married<br><i>3</i> Widowed <i>4</i> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><i>1</i> Yes <i>2</i> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><i>1</i> Yes <i>2</i> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i>      |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>5th</i> College (1-4 or 5+) <i>DA</i>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Cab Driver</i>   |  |   |  | 16b. Kind of Business/Industry<br><i>Royal Cab Co.</i>                       |  |   |  |
| To Be Completed by Physician/Medical Examiner                        | 17. Father's Name (First, Middle, Last)<br><i>Joseph Lee</i>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Lillian Holmes</i>  |  |  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Pamela Lee - wife</i>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2819 Ruscombe Lane Balto. md. 21215</i>       |  |  |  |   |  |
|  | 20a. Method of Disposition<br><i>1</i> Burial <i>2</i> Cremation <i>3</i> Removal from State<br><i>4</i> Donation <i>5</i> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>King Memorial Park</i>  |  | 20c. Location - City or Town, State<br><i>228-91 Randallstown, md</i>   |  |  |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Phyllis B. Harris</i>   |  | 22. Name and Address of Facility<br><i>March Funeral Home - West 4300 Wabash Ave. Balto. md. 21215</i>   |  |   |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Renal Failure</i><br>Due to (or as a consequence of):<br>b. <i>Diabetes</i><br>Due to (or as a consequence of):<br>c. <i>Dementia</i><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br><i>Unknown</i><br><i>Unknown</i><br><i>Unknown</i>                    |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Heart Disease</i>  |  |  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><i>1</i> Yes <i>2</i> No <i>3</i> Probably <i>4</i> Unknown |  |
|  |   |  |  |  |   |  |  |  | 24a. Was an autopsy performed?<br><i>1</i> Yes <i>2</i> No  |  |
|  |   |  |  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><i>1</i> Yes <i>2</i> No               |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><i>1</i> Yes <i>2</i> No  |  | 26. Place of Death (Check only one)<br>Hospital: <i>1</i> Inpatient <i>2</i> ER/Outpatient <i>3</i> DOA Other: <i>4</i> Nursing Home <i>5</i> Residence <i>8</i> Other (Specify) |  |   |  |  |  |   |  |
|  | 27. Manner of Death<br><i>1</i> Natural <i>5</i> Pending investigation<br><i>2</i> Accident <i>6</i> Could not be determined<br><i>3</i> Suicide<br><i>4</i> Homicide   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><i>M</i>   |  | 28c. Injury at Work?<br><i>1</i> Yes <i>2</i> No                             |  | 28d. Describe how Injury occurred   |  |
|  |   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |  |
|  | 29a. Certifier (Check only one)<br><i>1</i> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><i>2</i> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br><i>Arthur Jodanis MD</i>  |  | 29c. License number<br><i>50454</i>   |  | 29d. Date signed (Month, Day, Year)<br><i>February 24, 1997</i>              |  |   |  |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Northwest Hospital 5401 Old Court Road. Randallstown 21133</i>   |  |  |  |   |  |  |  |   |  |
|  | 31. Date filed (Month, Day, Year)<br><i>FEB 28 1997</i>   |  | 32. Registrar's Signature<br><i>J. Davidson-Randall</i>  |  |   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

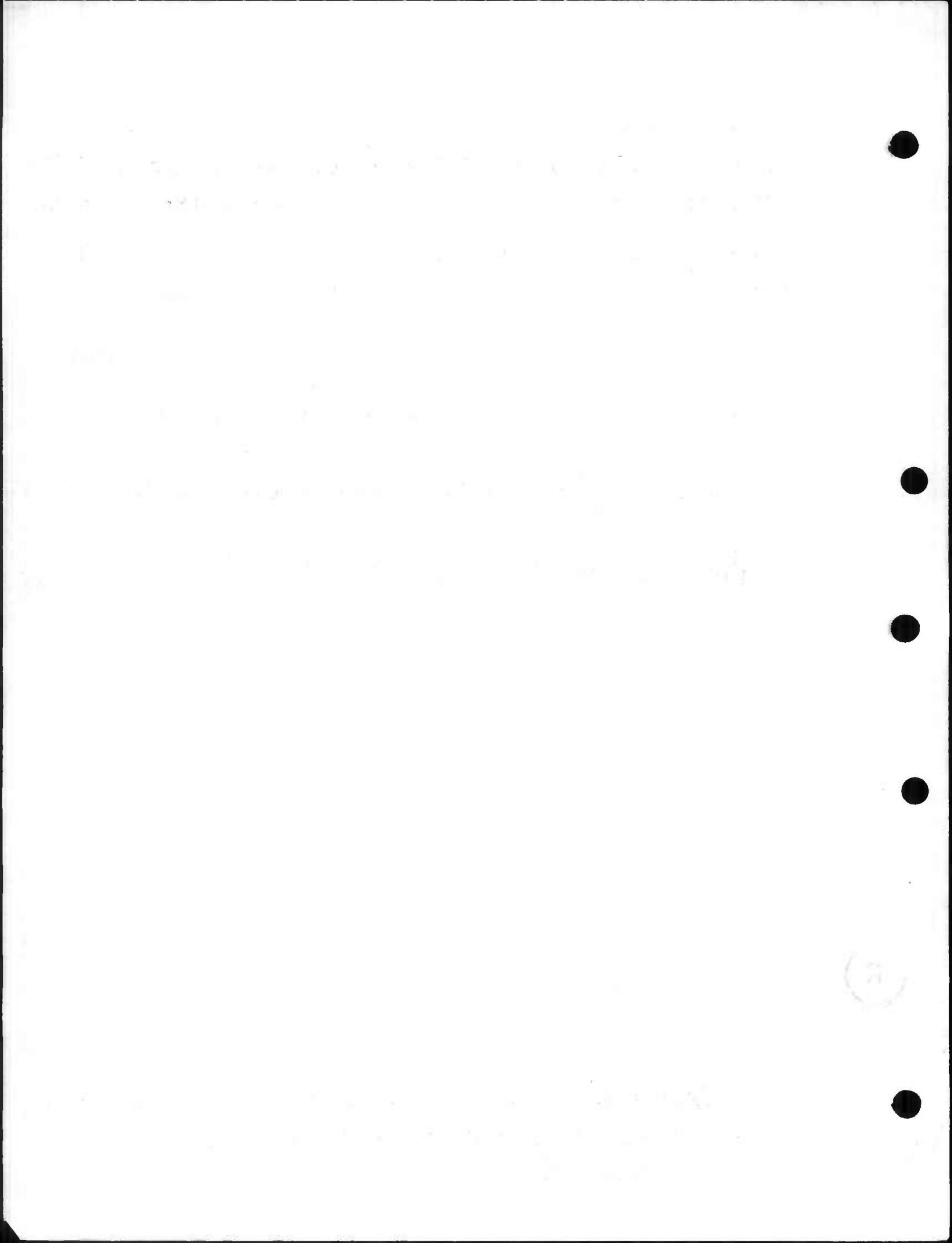
Physician  
/Medical  
Examiner

To the Hospital or to the Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06025

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Johnnie Mae Lumpkin

2. Date of Death

Month

Day

Year

02

27

97

3. Time of Death

0738A

4a. Facility Name (If not institution, give street and number)

Northwest Hosp. Tel Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

218-18-4082

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 3, 1924

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

md

10b. County

DA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

431 NORTE DAME LANE

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (14 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

18b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Thomas Watt

18. Mother's Name (First, Middle, Maiden Summa)

Pearl Clinkscales

19a. Informant's Name/Relationship (Type, Print)

Shiela Mason - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3604 Anne Hathaway Dr. Randallstown, md. 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON Forest &amp; Crem. 3/4/97

20c. Location - City or Town, State

Owings Mills, md

21. Signature of Funeral Service Licensee

D. Blynn B. Harris

22. Name and Address of Facility

March Funeral Home - West 21215

4300 Wabash Ave. Balto. md

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):

Upper Respiratory Obstruction

Approximate Interval Between Onset and Death

2 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Tracheostomy

Due to (or as a consequence of):

Respiratory Failure

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Non Insulin-Dependent Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D39050

29d. Date signed (Month, Day, Year)

2/27/97

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

1838 Green tree Rd Baltimore MD 2108

LEONARD RAUCHER

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06026

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ida May Loukota

2. Date of Death

February 25, 1997

3. Time of Death

6:00 PM

4a. Facility Name (If not institution, give street and number)

Eastpoint Nursing Home

4b. City, Town, or Location of Death

Eastpoint

4c. County of Death

Baltimore Co.

Funeral  
Director

5. Social Security Number

214-14-7526

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

Feb. 24, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3127 Vulcan Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Unknown

Bauernshub

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy

Unknown

19a. Informant's Name/Relationship (Type, Print)

Mrs. Barbara L. Westerman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3127 Vulcan Road Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Parkwood Cemetery 2/28/1997

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Brian A. Willem

22. Name and Address of Facility

Leonard J. Ruck Funeral Home, Inc.

5305 Harford Road Baltimore, MD 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PERIPHERAL VASCULAR DISEASE

PNEUMONIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
Investigation6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. C. Veneracion Jr. MD

29c. License number

D13664

29d. Date signed (Month, Day, Year)

February 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B. C. VENERACION JR MD, 1576 MERRITT BLVD. BALTO, MD 21222

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

John Davidson

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 23 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06027

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES F. LUCAS, SR.

2. Date of Death

Month Day Year  
FEBRUARY 27 1997

3. Time of Death

12:58PM

4a. Facility Name (If not institution, give street and number)

1436 PATAPSCO STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

218-26-3197

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
DEC. 7 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Md.10b. County  
n/a10c. City, Town or Location  
Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1436 Patapsco Street

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give Year or Dates  
Korea13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
9College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

W.R. Grace

17. Father's Name (First, Middle, Last)

James E. Lucas

18. Mother's Name (First, Middle, Maiden Surname)

Anna M. Martin

19a. Informant's Name/Relationship (Type, Print)

Marjorie E. Lucas/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1436 Patapsco Street Baltimore, Md. 21230

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Crownsville V.A. Cem.

Date

MARCH  
3 1997

20c. Location - City or Town, State

Crownsville, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully Funeral Home of South Balto.  
130 E. Fort Ave. Baltimore, Md. 2123023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. Lung Cancer  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ OOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D39505

29d. Date signed (Month, Day, Year)

Feb. 28, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Markman, 1406-B Crain Highway Glen Burnie MD 21061

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed within 24 hours after death. To the Hospital or Attending Physician: After the death certificate has been signed by the attending physician and to the Funeral Director: After the death certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06028

## Certificate of Death

Reg. No.

|  |   |   |  |   |   |   |  |  |  |  |
|--|---|---|--|---|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Priscilla E. Murray</b>                    |   |  |   | 2. Date of Death<br>Month: <b>02</b> Day: <b>24</b> Year: <b>97</b> |   | 3. Time of Death<br><b>2:30 pm</b>                         |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>5218 Darien Road</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>            |   | 4c. County of Death<br><b>NA</b>                           |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>121-26-5354</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.                    |   | 8. Date of Birth (Month, Day, Year)<br><b>NOV. 2, 1934</b> |  |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                               |   | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>n/a</b>   |   | 10c. City, Town or Location<br><b>BALTIMORE</b>            |  |  |  |
| Usual Residence of Decedent  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>5218 DARIEN ROAD</b>   |   | 10f. Zip Code<br><b>21206</b>   |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>unk.</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                               |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 th</b> College (1-4or 5+) <b>-</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CLERICAL</b>                                  |  | 16b. Kind of Business/Industry<br><b>JOHNS HOPKINS HOSPITAL</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>HORACE ROLLINS</b>                                      |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ISABELLE GRIFFIN</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>LEON MURRAY</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5218 DARIEN RD., BALTO., MD #06</b>   |   |   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GARRISON FOREST VA CEM.</b>  |   | 20c. Location - City or Town, State<br><b>02-28 OWINGS MILLS, M</b>                                   |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>S. Valencia Holland</b>  |   |   |  | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202</b><br><b>WM.C. March FH 1101 E. North Avenue</b>  |   |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Esophageal cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. c. d.</b><br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |   |   |  |   |   | Approximate Interval Between Onset and Death<br><b>6 months</b>                                       |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Malnutrition, dysphagia</b>   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
| 28d. Describe how injury occurred  |   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                          |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  | 29b. Signature and title of certifier<br><b>Wayne M. Koch</b>   |   | 29c. License number<br><b>D35051</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/25/97</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>WAYNE M. KOCH, MD</b>   |   |   |  | <b>PO Box 4402 Balto, MD 21203-4402</b>   |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 28 1997</b>  |   |   |  | 32. Registrar's Signature<br><b>John Madison-Randall</b>  |   |   |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06029

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Natilla Mary Moreau

2. Date of Death

February 25, 1997

3. Time of Death

7:45 PM

4a. Facility Name (If not institution, give street and number)

East Point Nursing Home

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

5. Social Security Number

023-12-5650

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 22, 1923

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4124 Eder Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Henry J. LaCourse

18. Mother's Name (First, Middle, Maiden Surname)

Ellen V. Curtis

19a. Informant's Name/Relationship (Type, Print)

Roy L. Carpenter/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2120 Maple Road Edgemere, Maryland 21219

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp. 2/28/1997

Date

20c. Location - City or Town, State

Towson, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardio pulmonary Arrest

Due to (or as a consequence of):

b. Metastatic Colon Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hepatic Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

N/A

28b. Time of Injury

N/A M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

N/A

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N/A

29a. Certifier (Check only one)

1 ☐ Medical Examiner 2 ☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D 43725

29d. Date signed (Month, Day, Year)

2/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MANMOOD 3400 ERDMAN AVE BALTO. MD. 21213

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06030

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Lillian J. Muir

2. Date of Death

February 21 1997 9:00pm

3. Time of Death

4e. Facility Name (If not institution, give street and number)

2912 Knoll Acres Drive

4b. City, Town, or Location of Death

Carney

4c. County of Death

Baltimore

5. Social Security Number

216-18-7474

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 30, 1910

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

Maryland Baltimore

Carney

10e. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2912 Knoll Acres Drive

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8 yrs

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Reese Johnson

18. Mother's Name (First, Middle, Maiden Surname)

May Unknown

19e. Informant's Name/Relationship (Type, Print)

Ken Muir / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2912 Knoll Acres Dr. Carney, Md 21234

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Memorial Park

Date

February 25, 1997

20c. Location - City or Town, State

Parkville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Evans Chapel of Memories  
8800 Harford Rd Parkville, Md 21234

23e. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. C.O.D.P.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Smoking

Due to (or as a consequence of):

years

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CVA, Dementia, Seizures

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D39757

29d. Date signed (Month, Day, Year)

February 25, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Lutfi A. Sayyur 5601 Loch Raven Blvd. Baltimore, Md. 21239

31. Date filed (Month, Day, Year)

Feb 28 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06031

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RACHEL ANN MILLER

2. Date of Death

Feb. 25, 1997

3. Time of Death

8:24AM

4a. Facility Name (If not institution, give street and number)

BelForest Nursing Home

4b. City, Town, or Location of Death

Forest Hill

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

213-74-9640

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

96

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 14, 1900

9. Birthplace (State or Foreign Country)

Baltimore, Md.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Joppa

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1607 Holly Drive

10f. Zip Code

21085

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
9th.College (1-4 or 5+)  
n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Winter Davis Horton

18. Mother's Name (First, Middle, Maiden Surname)

Annie Bates

19a. Informant's Name/Relationship (Type, Print)

Mrs. Elizabeth D. Ewing (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1607 Holly Drive Joppa, Md. 21085

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery Feb. 28, 1997

Data

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

E. F. Lassahn Funeral Home  
11750 Belair Road Kingsville, Md. 21087

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *End-stage cardiac disease*  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.   
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

25 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

C.V.A. - cerebral vascular accident

C.O.P.D. chronic obstructive pulmonary disease

H.T.N. Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D32277

29d. Date signed (Month, Day, Year)

February 25, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

David S. Dunn 615 West MacPhail

31. Date filed (Month, Day, Year)

FEB 28 1997

Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

to the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06032

Item: 23 part I, per physician G-745 3/18/97 re **Certificate of Death**

Reg. No.

|   |  |   |  |   |  |   |   |   |  |
|---|--|---|--|---|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MORTON MUFSON</b>                           |   |  |   | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>24</b> Year <b>1997</b> |   | 3. Time of Death<br><b>7:20 A.M.</b>                        |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Suburban Hospital</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Bethesda</b>                  |   | 4c. County of Death<br><b>Montgomery</b>                    |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>102-05-0369</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.                         |   | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 12, 1907</b> |   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>New York</b>                                |   | 10a. State<br><b>Md</b>  |   | 10b. County<br><b>Montgomery</b>   |   | 10c. City, Town or Location<br><b>Rockville</b>             |   |  |
| Usual Residence of Decedent   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>6121 Montrose Road</b>   |  | 10f. Zip Code<br><b>20852</b>   |   | 10g. Citizen of What Country?<br><b>U. S. A.</b>                          |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12 Years</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Retail</b>  |  | 16b. Kind of Business/Industry<br><b>Shoe Trade</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Louis Mufson</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Etta Jacobson</b> |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert A. Mufson</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5917 Wilmet Road, Bethesda, Maryland 20817</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Beth Moses Cemetery 2/26/1997</b>                          |   | 20c. Location - City or Town, State<br><b>Pinelawn, L.I., New York</b>    |  |
| 21. Signature of Funeral Service Licensee<br><b>Donald C. Stettin</b>   |  | 22. Name and Address of Facility<br><b>STEIN HEBREW MEMORIAL FUNERAL HOME, INC.</b><br><b>232 CARROLL STREET. N.W., WASHINGTON, D.C. 20012</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>SEPSIS</b><br><b>ATHERO SCLEROTIC HEART DISEASE</b><br>Due to (or as a consequence of):<br>a. _____<br>Due to (or as a consequence of):<br>b. _____<br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____ |  | Approximate Interval Between Onset and Death<br><b>YEARS</b>  |   |   |  |
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEMENTIA</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Piece of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>P. Talwar, M.D.</b>   |  | 29c. License number<br><b>D36552</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 25 1997</b>  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>P-TALWAR M.D. 6121 MONTROSE ROAD ROCKVILLE MD. 20852</b>   |  | 31. Date filed (Month, Day, Year)<br><b>FEB 28 1997</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |   |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06033

Reg. No.

|   |   |   |  |   |   |   |   |  |
|---|---|---|--|---|---|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MARGARET PUSKARIC</b>                    |   |  |   | 2. Date of Death<br>Month <b>2</b> Day <b>24</b> Year <b>97</b> |   | 3. Time of Death<br><b>1:00 PM</b>                          |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>FRANKLIN WOODS</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>N/A</b>              |   | 4c. County of Death<br><b>BALTIMORE</b>                     |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-24-6772</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.                |   | 8. Date of Birth (Month, Day, Year)<br><b>June 22, 1916</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                             |   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Baltimore</b>                                 |   | 10c. City, Town or Location<br><b>Baltimore</b>             |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><b>37 Sipple Avenue</b>   |  | 10f. Zip Code<br><b>21236</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>8th grade</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Meat Packer</b>                   |  | 16b. Kind of Business/Industry<br><b>Meat Company</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>George Willinger</b>  |   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Greenwood</b>  |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joan Booz (Daughter)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>215 Robwood Road, Baltimore, Maryland 21222</b>   |   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                   |   |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gardens of Faith Cem.</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>   |  | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Schimunek Funeral Home</b><br><b>3331 Brehms Lane, Baltimore, Maryland 21213</b>   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Abdominal Mucinous Adenocarcinoma</b> |   | Approximate Interval Between Onset and Death<br><b>6 mo.</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                 |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |   |  |
| 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred   |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>William D. Hakkarinen MD</b>  |   |  |
| 29c. License number<br><b>DO 8252</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>Feb. 25, 1997</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>WILLIAM D. HAKKARINEN, MD FRANKLIN SQUARE HOSPITAL, BALTO. MD</b>  |   | 31. Data filed (Month, Day, Year)<br><b>FEB 28 1997</b>   |   |  |
| 32. Registrar's Signature<br>   |   |   |  |   |   |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

Abraham Lincoln

Abraham Lincoln  
1809-1865



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06034

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Heather Prezioso

2. Date of Death

February 22 1997 2:12 PM

3. Time of Death

2:12 PM

4a. Facility Name (If not institution, give street and number)

Shock Trauma Center RTC

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

217-29-2109

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

6

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 10, 1990

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

711 White Oak Drive

10f. Zip Code

21014

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

Kindergarden

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Student

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Jeffrey Prezioso

18. Mother's Name (First, Middle, Maiden Surname)

Robin Neumyer

19a. Informant's Name/Relationship (Type, Print)

Robin Prezioso (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

711 White Oak Drive, Bel Air, MD. 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Bel Air Memorial Gardens 3/1/97

Date

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.  
610 W. MacPhail Road, Bel Air, MD. 2101423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. motor vehicle accident causing multiple traumatic injuries

Approximate  
Interval Between  
Onset and Death

1 hour

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient3 ☒ DOA

Other:

28. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☒ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

Feb 22, 1997

28b. Time of Injury

1:00 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

motor vehicle accident

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

Roadway

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

RT 24

29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

P08648

29d. Date signed (Month, Day, Year)

Feb 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Karen Dettmer 11 S. Greene St. N5W56 Balto, MD 21201

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06035

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MATILDA. PUSKAR

2. Date of Death

Month

Day

Year

FEBRUARY-22-1997

3. Time of Death

8:30 AM

4a. Facility Name (If not institution, give street and number)

CHURCH HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE - MARYLAND

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

215-05-4480

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 23, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Edgemere

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6607 North Point Road

10f. Zip Code

21219

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Retail

16b. Kind of Business/Industry

Feed Store

17. Father's Name (First, Middle, Last)

Joseph Stranzyski

18. Mother's Name (First, Middle, Maiden Surname)

Florence Unknown

19a. Informant's Name/Relationship (Type, Print)

Dorothy A. Roycroft/Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3018 Salisbury Avenue Edgemere, MD 21219

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Stanislaus Cemetery 2/25/1997 Dundalk, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

John L. 1106

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. LUNG CANCER

Due to (or as a consequence of):

JANUARY 1997

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PNEUMONIA

Due to (or as a consequence of):

FEBRUARY 1997

c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Riffat Mahmud MD

29c. License number

D44073

29d. Date signed (Month, Day, Year)

FEBRUARY 22 - 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RIFFAT-MAHMUD CHURCH HOSPITAL

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This certificate requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 3, 1863. It is a very important document, as it contains the President's message to Congress, which is a key part of the executive branch's communication with the legislative branch. The letter is written in a formal, official style, and it is signed by the President.

2. The second part of the document is a letter from the Secretary of the Treasury to the Congress, dated January 3, 1863. It is also a very important document, as it contains the Secretary's report to Congress, which is a key part of the executive branch's communication with the legislative branch. The letter is written in a formal, official style, and it is signed by the Secretary.

3. The third part of the document is a letter from the Secretary of the Navy to the Congress, dated January 3, 1863. It is also a very important document, as it contains the Secretary's report to Congress, which is a key part of the executive branch's communication with the legislative branch. The letter is written in a formal, official style, and it is signed by the Secretary.

4. The fourth part of the document is a letter from the Secretary of the War to the Congress, dated January 3, 1863. It is also a very important document, as it contains the Secretary's report to Congress, which is a key part of the executive branch's communication with the legislative branch. The letter is written in a formal, official style, and it is signed by the Secretary.

8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06036

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Frieda Picarello

2. Date of Death

February 22

Day Year  
1997

3. Time of Death

6:15 pm

4a. Facility Name (If not institution, give street and number)

ST. AGNES NURSING HOME

4b. City, Town, or Location of Death

ELLCOTT CITY

4c. County of Death

HOWARD

5. Social Security Number

212-10-4869

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

AUG 29 1916

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

911 WILTON DRIVE

10f. Zip Code

21227

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

COMPUTER OPERATOR

16b. Kind of Business/Industry

FEDERAL

GOVERNMENT

17. Father's Name (First, Middle, Last)

ALVIN WODE

18. Mother's Name (First, Middle, Maiden Surname)

MARIE BELOFF

19a. Informant's Name/Relationship (Type, Print)

DAWN JACOBS, DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

911 WILTON DR., BALT., MD 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

LAKEVIEW MEMORIAL PK 2-26

Date

20c. Location - City or Town, State

SYKESVILLE, MD

21. Signature of Funeral Service Licensee

Phyllis Harris

22. Name and Address of Facility

STERLING ASHTON FUNERAL HOME, INC.

736 EDMONDSON AVE., BALT., MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Atherosclerotic cerebrovascular disease

mon

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Laurena R. Gallagher, MD

29c. License number

D 01786

29d. Date signed (Month, Day, Year)

Feb 24, 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laurena R. Gallagher MD 714 Maiden Choice La Gaithersburg MD 20878

31. Date (Month, Day, Year)

FEB 28 1997

Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: This law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06037

## Certificate of Death

Reg. No.

|  |   |  |  |   |   |  |  |  |
|--|---|--|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>GEORGE P REGNER JR.   |  |  |   | 2. Date of Death<br>Month Day Year<br>February 24, 1997   |  | 3. Time of Death<br>8:30 P.M.  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br>STELLA MARIS HOSPICE  |  |  |   | 4b. City, Town, or Location of Death<br>BALTIMORE Co Md   |  | 4c. County of Death<br>BALTIMORE   |  |
| Funeral<br>Director  | 5. Social Security Number<br>213-18-3262  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br>75 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>July 4 1921   |  |
|  | Usual Residence of Decedent   |  | 9. Birthplace (State or Foreign Country)<br>MARYLAND   |   | 10a. State<br>Md  |  | 10b. County<br>BALTIMORE   |  |
| To Be Completed by Funeral Director  | 10c. City, Town or Location<br>BALTIMORE Co Md  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br>2406 LAMPOST LANE   |  | 10f. Zip Code<br>21234   |  |
|  | 10g. Citizen of What Country?<br>USA  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WWII  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>ELECTRICAL ENGINEER BALTIMORE CITY   |  | 16b. Kind of Business/Industry   |  |
|  | 17. Father's Name (First, Middle, Last)<br>GEORGE P REGNER SR   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>LEONA GEORGE  |   | 19a. Informant's Name/Relationship (Type, Print)<br>ANDREY M. REGNER  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2406 LAMPOST LA. BALTO Md 21234   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>GREENMOUNT CREMATORY   |   | 20c. Date<br>2/26/97  |  | 20d. Location - City or Town, State<br>BALTIMORE   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br>HARTLEY MILLER FUNERAL HOME<br>7527 HARFORD RD. BALTO Md 21234   |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. COLON CANCER w/ metastases |  | Approximate Interval Between Onset and Death<br>2 mos.   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  | 26. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 27a. Date of Injury (Month, Day, Year)   |   | 27b. Time of Injury<br>M  |  | 27c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  | 27d. Describe how Injury occurred   |  | 27e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 27f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>Kendall E Faulkner  |   | 29c. License number<br>225643   |  | 29d. Date signed (Month, Day, Year)<br>2/25/97   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204 |   | 31. Date filed (Month, Day, Year)<br>FEB 28 1997 |  | 32. Registrar's Signature<br>Julia Davidson-Rendell |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <b>ANNE ROBERTS</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>02</b> DAY <b>23</b> YEAR <b>97</b>   |  | 3. TIME OF DEATH<br><b>12:45 P.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>058-26-9970</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>62</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>05 01 34</b>  |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>LARKIN CHASE NSG &amp; RESTORATIVE CENTER</b>   |  |  |  | 9. CITY, TOWN OR LOCATION OF DEATH<br><b>BOWIE, MD</b>   |  | 10. COUNTY OF DEATH<br><b>PRINCE GEORGE'S</b>  |  |
| 11. RESIDENCE OF DECEDENT   |  |  |  | 12. STATE<br><b>Maryland</b>   |  | 13. 10b. COUNTY<br><b>Prince Georges</b>   |  |
| 14. 10c. CITY, TOWN OR LOCATION<br><b>College Park</b>  |  |  |  | 15. 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 16. 10e. STREET AND NUMBER<br><b>6100 Westchester Park Dr. Apt 615</b>   |  |
| 17. 10f. ZIP CODE<br><b>20747</b>   |  |  |  | 18. 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 19. 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 20. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 21. 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 22. 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 23. 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 years</b><br>College (1-4 or 5+) <b>Secretary</b>   |  |  |  | 24. 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Secretary</b>  |  | 25. 16b. KIND OF BUSINESS/INDUSTRY<br><b>Federal Government</b>  |  |
| 26. 17. FATHER'S NAME (First, Middle, Last)<br><b>Patrick Conway</b>  |  |  |  | 27. 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sarah Caffrey</b>  |  |  |  |
| 28. 19a. INFORMANT'S NAME (Type/Print)<br><b>Margaret Tanavage (Sister)</b>   |  |  |  | 29. 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3730 Coronado Rd. Baltimore, MD 21244</b>  |  |  |  |
| 30. 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 31. 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Carroll Cremation, Inc. 2-25</b>   |  | 32. 20c. LOCATION — City or Town, State<br><b>Hampstead, Maryland</b>  |  |
| 33. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John K. Agnew</i>   |  |  |  | 34. 22. NAME AND ADDRESS OF FACILITY<br><b>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Rd. Randallstown, MD 21133</b>  |  |  |  |
| 35. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Carcinoma of Pancreas</b> Approximate Interval Between Onset and Death <b>Few months</b><br><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |  |  |  |  |  |  |
| 36. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  | 37. 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 38. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  | 39. 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 40. 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  | 41. 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |  |  |
| 42. 28a. DATE OF INJURY (Month, Day, Year)  |  | 43. 28b. TIME OF INJURY<br><b>M</b>  |  | 44. 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 45. 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 46. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 47. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 48. 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |
| 49. 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Rakesh Arora MD</b>   |  |  |  | 50. 29c. LICENSE NUMBER<br><b>D 20108</b>  |  | 51. 29d. DATE SIGNED (Month, Day, Year)<br><b>2/24/97</b>  |  |
| 52. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>RAKESH ARORA, MD 14300 GALLANT FOX LN BOWIE MD 20715</b>  |  |  |  |  |  |  |  |
| 53. 31. DATE FILED (Month, Day, Year)<br><b>FEB 28 1997</b>   |  |  |  | 54. 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06039

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth A. KASSA

2. Date of Death

February

Day

23

Year

1997

3. Time of Death

5:30 AM

4a. Facility Name (If not institution, give street and number)

Genesis Elder Care

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

212 07 7219-B

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 11 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6309 Eunice Ave.

10f. Zip Code

21214

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8 yrs.

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

William E. Deck

18. Mother's Name (First, Middle, Maiden Surname)

Mary G. Winkle

19a. Informant's Name/Relationship (Type, Print)

Edward A. KASSA Sr. / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6309 Eunice Ave. Baltimore, Maryland 21214

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) Entombment20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parkwood Cemetery

Date

February  
26 1997

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Eunice R. Kassar

22. Name and Address of Facility

EVANS Chapel of Memories

8800 Harford Rd Baltimore, MD 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

CEREBELLAR ATAXIA

Approximate  
Interval Between  
Onset and Death

YEARS

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day, Year)

N/A

28b. Time of Injury

(Month, Day, Year)

N/A

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

N/A

28d. Describe how injury occurred

N/A

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

N/A

29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John P. Evelius

29c. License number

D34952

29d. Date signed (Month, Day, Year)

February 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Thomas Evelius

5444 Belair Rd. Baltimore, Maryland

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

John P. Evelius

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06040

## Certificate of Death

Reg. No.

|   |  |   |  |  |  |  |  |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
|---|--|---|--|--|--|--|--|---|---|---------------------------|----------------------------------|---|---------------------|----------------------------------|---------------|---------------------------------|----------------------------------|----------------|----|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MATTHEW F. RACIOPPA</b>   |   |  |  | 2. Date of Death<br>Month Day Year<br><b>February 26, 1997</b>   |  | 3. Time of Death<br><b>3:35 PM</b>   |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>NORTH ARUNDEL Hospital</b>  |   |  |  | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>   |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>   |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>206-26-4275</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (in yrs. last birthday)<br><b>62</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>May 17, 1934</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b> |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
|   | Usual Residence of Decedent  |   |  |  |  |  |  |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD.</b>   |   | 10b. County<br><b>Anne Arundel</b>   |  | 10c. City, Town or Location<br><b>Glen Burnie</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
|   | 10e. Street and Number<br><b>102 Crain HWY. Apt 960</b>  |   |  |  | 10f. Zip Code<br><b>21061</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Korea</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4or 5+) <b>0</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Security Guard</b>                             |  | 16b. Kind of Business/Industry<br><b>Sears Roebuck And CO.</b>   |  |  |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Frank Paul Racioppa</b>  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary L. Genell</b>   |  |  |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary Racioppa (Mother)</b>  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Apt. 960<br/>102 Crain HWY. Glen Burnie, Maryland 21061</b>                              |  |  |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Glen Haven Mem. Park</b>  |  | Date<br><b>2/28/97</b>   |  | 20c. Location - City or Town, State<br><b>Glen Burnie, Maryland</b>                            |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Kevin E. Ecker</b>   |   |  |  | 22. Name and Address of Facility<br><b>McCully Funeral Home of Brooklyn<br/>237 E. Patapsco Ave. Balto., MD. 21225</b>   |  |  |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |  |  |  |  |  |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
|   | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Sepsis syndrome</b></td> <td>Due to (or as a consequence of):</td> <td>Approximate interval Between Onset and Death<br/><b>1 week</b></td> </tr> <tr> <td>b. <b>Pneumonia</b></td> <td>Due to (or as a consequence of):</td> <td><b>1 week</b></td> </tr> <tr> <td>c. <b>Non Hodgkins Lymphoma</b></td> <td>Due to (or as a consequence of):</td> <td><b>3 years</b></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> |   |  |  |  |  |  |   | Immediate Cause (Final disease or condition resulting in death) | a. <b>Sepsis syndrome</b> | Due to (or as a consequence of): | Approximate interval Between Onset and Death<br><b>1 week</b> | b. <b>Pneumonia</b> | Due to (or as a consequence of): | <b>1 week</b> | c. <b>Non Hodgkins Lymphoma</b> | Due to (or as a consequence of): | <b>3 years</b> | d. |  |
| Immediate Cause (Final disease or condition resulting in death)   | a. <b>Sepsis syndrome</b>  | Due to (or as a consequence of):  | Approximate interval Between Onset and Death<br><b>1 week</b>  |  |  |  |  |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
|   | b. <b>Pneumonia</b>  | Due to (or as a consequence of):  | <b>1 week</b>  |  |  |  |  |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
|   | c. <b>Non Hodgkins Lymphoma</b>  | Due to (or as a consequence of):  | <b>3 years</b>   |  |  |  |  |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
|   | d.   |   |  |  |  |  |  |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
|   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
|   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  |  |  |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
| 29b. Signature and title of certifier<br><b>Stuart Jacobs MD</b>  |  |   |  | 29c. License number<br><b>022483</b>             |  | 29d. Date signed (Month, Day, Year)<br><b>February 26, 1997</b>  |  |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>STUART JACOBS MD North Arundel Hospital Glen Burnie, MD 21061</b>  |  |   |  |  |  |  |  |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 28 1997</b>   |  | 32. Registrar's Signature<br><b>Julia Gordon-Podella</b>  |  |  |  |  |  |   |   |                           |                                  |   |                     |                                  |               |                                 |                                  |                |    |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

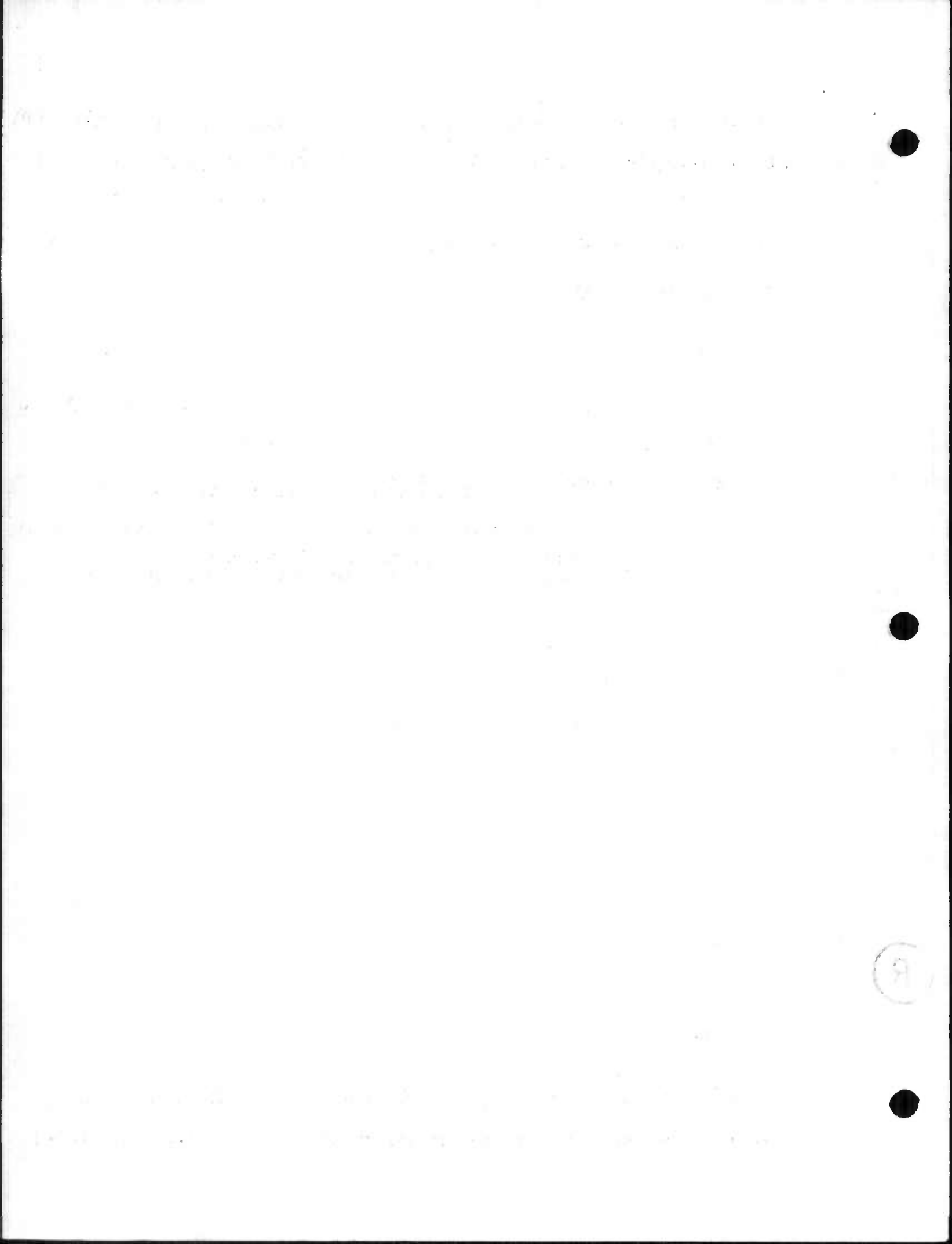
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06041

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Rhoda Raider

2. Date of Death

Month Day Year  
February 20 1997

3. Time of Death

5:20am

4a. Facility Name (If not institution, give street and number)

716 Burnt Mills Court

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

579 18 3105

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 13 1922

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

716 Burnt Mills Court

10f. Zip Code

20901

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Co-President

16b. Kind of Business/Industry

Advertising Agency

17. Father's Name (First, Middle, Last)

Alfred Bandler

18. Mother's Name (First, Middle, Maiden Surname)

Gussie Herman

19a. Informant's Name/Relationship (Type, Print)

Linda Raider Krauss/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14563 Cutstone Way Silver Spring, Md. 20905

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

King David Memorial

Date

2/24/97

20c. Location - City or Town, State

Falls Church, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ives-Pearson Funeral Homes

472 N. Washington St. Falls Church, VA

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Endometrial Cancer

Due to (or as a consequence of):

7 Years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how Injury occurred

29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D32407

29d. Date signed (Month, Day, Year)

February 20, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9707 Medical Center Dr. Suite 300 Rockville Md. 20850 - Joseph M. Haggerty MD

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06042

## Certificate of Death

Reg. No.

|  |   |  |   |                           |  |   |  |  |
|--|---|--|---|---------------------------|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Elmer Leroy Russell</b>  |  |   |                           | 2. Date of Death<br>Month <b>February</b> Day <b>24</b> , Year <b>1997</b>   |   | 3. Time of Death<br><b>11:50 PM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Bel Forest Nursing &amp; Rehabilitation Center</b>   |  |   |                           | 4b. City, Town, or Location of Death<br><b>Forest Hill</b>   |   | 4c. County of Death<br><b>Harford</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-05-6880</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.  | If Under 1 Year<br>Months | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Sept. 26, 1911</b> | 9. Birthplace (State or Foreign Country)<br><b>Baltimore Co. Md.</b>   |  |
|  | Usual Residence of Decedent   |  |   |                           |  |   |  |  |
| To Be Completed by Funeral Director  | 10e. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>   |                           | 10c. City, Town or Location<br><b>Glen Arm</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|  | 10e. Street and Number<br><b>4937 Long Green Road</b>   |  |   |                           | 10f. Zip Code<br><b>21057</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th.</b>   |  | Collage (1-4 or 5+) <b>n/a</b>  |                           | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Home Improvement</b>  |   | 16b. Kind of Business/Industry<br><b>Self-Employed</b>   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Harry W. Russell</b>  |  |   |                           | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Florence Mae Isenock</b>   |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ellen Russell (Wife)</b>   |  |   |                           | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4937 Long Green Road Glen Arm, Md. 21057</b>   |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fork Methodist Ch. Cem.</b>  |                           | Date<br><b>2/28/97</b>   |   | 20c. Location - City or Town, State<br><b>Fork, Maryland 21051</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>E. F. Lassahn</b>   |  |   |                           | 22. Name and Address of Facility<br><b>E. F. Lassahn Funeral Home<br/>11750 Belair Rd. Kingsville, Md. 21087</b>   |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. coronary artery disease</b><br>Dua to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. </b><br>Dua to (or as a consequence of):<br><b>c. </b><br>Dua to (or as a consequence of):<br><b>d. </b> |  |   |                           |  |   |  |  |
|  | Approximate Interval Between Onset and Death<br><b>1 year</b>   |  |   |                           |  |   |  |  |
| Physician<br>/Medical<br>Examiner  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>chronic obstructive pulmonary disease</b>  |  |   |                           |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |   |  |   |                           |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |   |  |   |                           |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                           |  |   |  |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |                           |  |   |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury<br>(Month, Day, Year)   |                           | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |                           | 28d. Describe how injury occurred  |   |  |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |                           |  |   |  |  |
|  | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |                           |  |   |  |  |
|  | 29b. Signature and title of certifier<br><b>E. F. Lassahn</b>   |  |   |                           | 29c. License number<br><b>028339</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>February 25, 1997</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>LINDA RUSSELL 101 E Wheel Road Bel Air MD 21055</b> |   |  |   |                           |  |   |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>FEB 28 1997</b>   |  |   |                           | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06043

Reg. No.

|  |   |  |   |  |  |  |  |  |
|--|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>AMELIA LOUISE BEISSEL RULENZ</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>February 23, 1997</b>   |  | 3. Time of Death<br><b>1:55 PM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>COLLEGE MANOR</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Lutherville</b>   |  | 4c. County of Death<br><b>Baltimore County</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>160-09-7509</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>May 17, 1914</b>                                     |  |
|  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore County</b>  |  | 10c. City, Town or Location<br><b>Middleborough</b>  |  | 10d. Inland City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| To Be Completed by Funeral Director  | 10e. Street and Number<br><b>1801 Elk Road</b>  |  |   |  | 10f. Zip Code<br><b>21221</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3 yrs</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Executive Secretary</b>           |  | 16b. Kind of Business/Industry<br><b>Medical</b>   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>J Frederick Beissel</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lu C Young</b>   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carole A. Schaefer (Daughter)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>200 Edgevale Road, Baltimore, Maryland 21210</b>   |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>2/26/97 Baltimore, Maryland</b>  |  | 20d. Date  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Martin D. Lawson</b>  |  |   |  | 22. Name and Address of Facility<br><b>Mitchell-Wiedefeld Home<br/>6500 York Road, Baltimore, Maryland 21212</b>   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. pneumonia</b><br>Due to (or as a consequence of):<br><b>b. aspiration</b><br>Due to (or as a consequence of):<br><b>c. swallowing difficulty</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |  |  |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |  |  |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |   |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia</b><br><b>Advanced age + debility</b>   |  |   |  |  |  |  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>College Manor</b> |  |  |  |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
|  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |  |  |
|  | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  |   |  | 29c. License number<br><b>024732</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2/24/97</b>  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>E. TIMOTHY SOUWEINE, M.D., 5124 Belmont Avenue, Towson, Maryland 21286</b>   |  |   |  |  |  |  |  |
| State<br>Registrar   | 31. Date of Registration<br><b>FEB 28 1997</b>  |  |   |  |  |  |  |  |
|  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06044

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN

REYNOLDS

2. Date of Death

Month Day Year  
FEB. 24 1997

3. Time of Death

9:05 AM

4a. Facility Name (If not institution, give street and number)

Stella Maris Mercy

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

213-03-9360

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov. 19, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1123 Carroll Street

10f. Zip Code

21230

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

grocer

16b. Kind of Business/Industry

self-employed

17. Father's Name (First, Middle, Last)

John J. Reynolds Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Dorn

19a. Informant's Name/Relationship (Type, Print)

Mark W. Reynolds, son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

276 Sheffield Road Severna Park, Maryland

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Loudon Park Cemetery 2/27

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ambrose Funeral Home of Lansdowne  
2719 Hammonds Ferry Road 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. METASTATIC CARCINOMA TO LIVER - PRIMARY UNKNOWN Months

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASVD s/p CABG, w/o colon ca

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

STELLA MARIS AT MERCY

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D40480

February 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FERNANDO J. FERRAZ, MD

5810 BELAIR RD  
BALTO, MD 21206

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

Lia Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06045

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John G Rhode

2. Date of Death

February 25, 1997

3. Time of Death

905 AM

4a. Facility Name (If not institution, give street and number)

Lorien Nursing Home

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

218-05-2437

6. Sex

1 ☐ M 2 ☐ F

7. Age (in yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11/03/1915

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1521 Woodcliff Ave.

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Pharmacist

16b. Kind of Business/Industry

Pharmaceutical

17. Father's Name (First, Middle, Last)

John Martin Rhode

18. Mother's Name (First, Middle, Maiden Surname)

Marguerite E. Bright

19a. Informant's Name/Relationship (Type, Print)

Carol Ehlers/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1304 Denbright Rd. Catonsville, MD. 21228

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Druid Ridge Cemetery 2/28/97 Pikesville, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Phillip Stach

22. Name and Address of Facility

Sterling Ashton Funeral Home, Inc.  
736 Edmondson Ave. Balto., MD. 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

History of Renal Insufficiency

Hypothyroidism

Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation 6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

J. A. Hunter

29c. License number

D44782

29d. Date signed (Month, Day, Year)

February 26, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J. A. HUNTER, MD 2 KNOLL NORTH, COLUMBIA, MD 21045

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

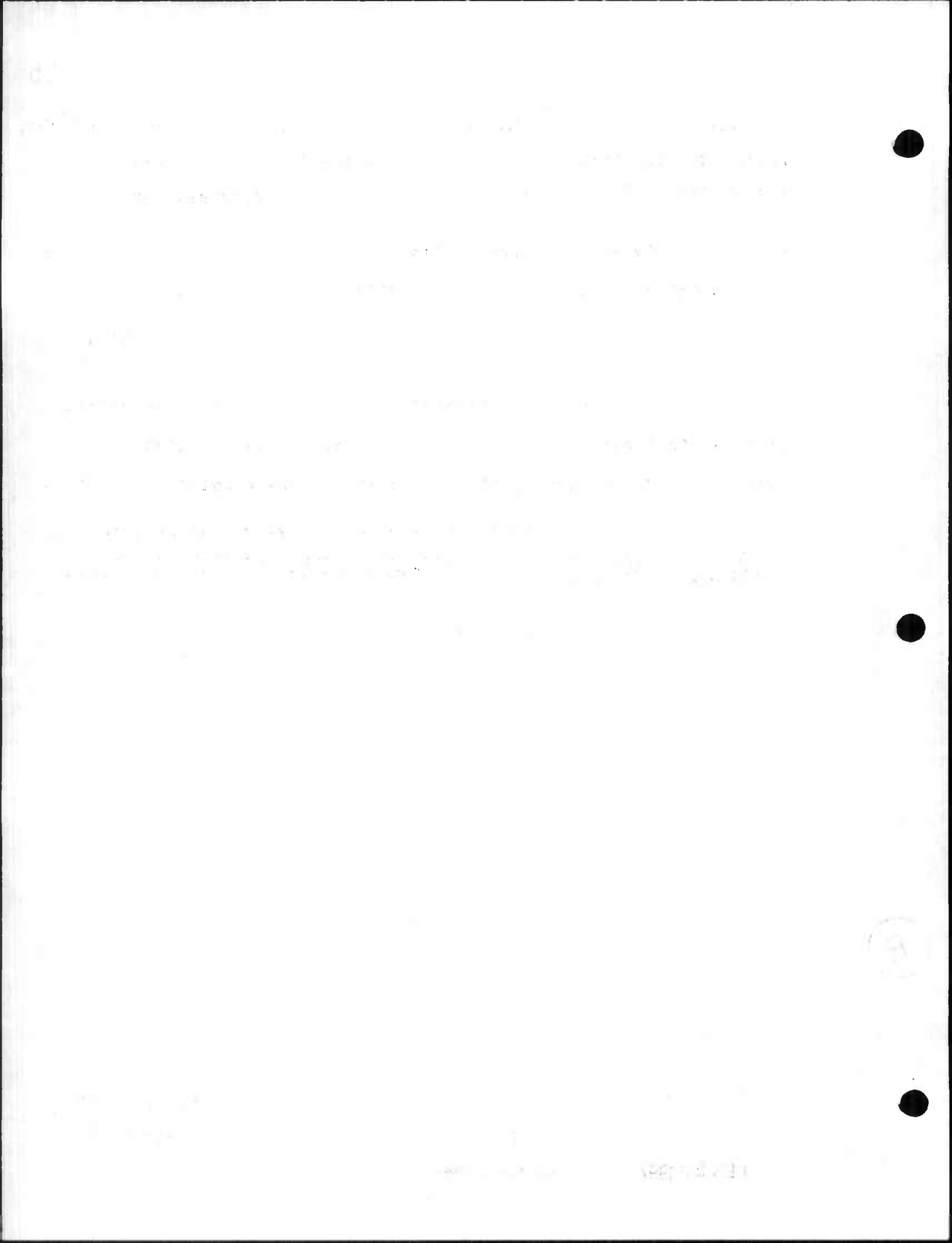
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





97 06046

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PEARL LORETTA Robinette</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 25 - 1997</b>   |  | 3. TIME OF DEATH<br><b>6:05 p.m.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-14-2665</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>93</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>12/11/1903</b>                                     |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Catonsville Commons</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Catonsville</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>N/A</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>820 S. Caton Ave.</b>   |  |  |  | 10f. ZIP CODE<br><b>21229</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 6</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>House Mother</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Convent/ School</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Goss</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Farber</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. John Robinette/Son</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2631 Northshire Dr. Baltimore, MD. 21230</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery 3/1/97 Baltimore, MD.</b>   |  | 20c. LOCATION — City or Town, State   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Sterling Ashton Funeral Home, Inc.<br/>736 Edmondson Ave. Balto., MD. 21228</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>BRONCHO PNEUMONIA</b>   |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |  |
| b. <b>Chronic Obstructive Pulmonary Disease</b>  |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| c. <b>Congestive Heart Failure</b>   |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| d.   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b>  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>N/A</b>   |  | 28b. TIME OF INJURY<br><b>N/A</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>N/A</b>  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>N/A</b>  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>N/A</b>      |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 30469</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>February 25, 1997</b>                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>N.B. VELLANKI, 9055, CHEVROLET DRIVE, #100, ELICOTT CITY, MD. 21042</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 28 1997</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.






Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06047

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |  |   |  |
|---|--|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>John William Sweeting</b>   |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>25</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>10:37 AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>FALLSTON GENERAL HOSPITAL</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>FALLSTON</b>   |  | 4c. County of Death<br><b>HARFORD</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>215-07-2736</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>JAN 10, 1911</b>                                  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10e. State<br><b>MD</b>   |  | 10b. County<br><b>HARFORD</b>   |  | 10c. City, Town or Location<br><b>BEL Camp</b>  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|   | 10e. Street and Number<br><b>1123 BEL Camp Rd.</b>   |  |   |  | 10f. Zip Code<br><b>21017</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+) <b>N/A</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CHAUFFEUR</b>                                 |  | 16b. Kind of Business/Industry<br><b>DELIVERY Co.</b>   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>JOHN E. SWEENEY</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LIZZIE BAIER</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs ANNA M. SWEETING</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1123 BEL Camp Rd.</b>   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>PARKWOOD Cemetery</b>  |  | 20c. Date<br><b>2/27</b>  |  | 20d. Location - City or Town, State<br><b>BALTO, MD.</b>                                    |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>HARTLEY MILLER FUNERAL HOME</b><br><b>7527 HARFORD RD. BALTO, MD. 21234</b>  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Myocardial Infarction</b><br>Due to (or as a consequence of):<br><b>b. Atherosclerotic Cardiovascular Disease 10 years</b><br>Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Colon Cancer</b><br><b>Respiratory Failure</b> |  |   |  |   |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                   |  |  |   |  |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |   |  |   |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M <input type="checkbox"/> P <input type="checkbox"/> A <input type="checkbox"/> N   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |  |   |  |
| State Registrar   | 29b. Signature and Title of Certifier<br>   |  |   |  | 29c. License number<br><b>H39022</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>February 26 1997</b>                              |  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Peter Lopresti 1308 Business Center Way Edgewood MD</b>   |  |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 28 1997</b>   |  |  |   | 32. Registrar's Signature<br> |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

UNKNOWN  
97 06048

Reg. No.

|   |   |  |   |  |  |  |   |  |
|---|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>DORETHA SHARON SCARBOROUGH  |  |   |  | 2. Date of Death<br>Month Day Year<br>FEBRUARY 20, 1997  |  | 3. Time of Death<br>9:50AM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>2674 PENNSYLVANIA AVENUE  |  |   |  | 4b. City, Town, or Location of Death<br>BALTIMORE  |  | 4c. County of Death<br>N/A  |  |
| Funeral<br>Director   | 5. Social Security Number<br>213-84-8651  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs, last birthday)<br>29 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Dec 4, 1967  |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland  |  | 10a. State<br>Maryland  |  | 10b. County<br>N/A   |  | 10c. City, Town or Location<br>Baltimore  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br>770 W. Saratoga St.   |  | 10f. Zip Code<br>21201   |  | 10g. Citizen of What Country?<br>USA  |  |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                |  |
| Physician<br>/Medical<br>Examiner   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>10 0  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Line server                              |  | 16b. Kind of Business/Industry<br>NSA  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br>George Scarborough   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elaine Partlow  |  |   |  |
| Physician<br>/Medical<br>Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Elaine Scarborough (Mother)  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>703 Lennox St. Apt. 1A Balto. Md. 21217   |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mt. Zion  |  | 20c. Location - City or Town, State<br>3/3/97 Lansdowne, Md.   |  |   |  |
| Physician<br>/Medical<br>Examiner   | 21. Signature of Funeral Service Licensee<br>Joseph L. Russ   |  |   |  | 22. Name and Address of Facility<br>Joseph L. Russ Funeral Home<br>2222 W. North Ave. Balto. Md. 21216   |  |   |  |
|   | 23a. Pertinent enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Strangulation<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death   |  |   |  |
| Division of Vital Records, P.O. Box 68760,  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |
|   |   |  |   |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once. | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)<br>ABANDONED WAREHOUSE |  |   |  |
|   | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)<br>Found 2-28-97  |  | 28b. Time of Injury<br>unknown   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 28d. Describe how Injury occurred<br>Subject was strangled  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>Warehouse   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>2674 Pennsylvania Avenue<br>Baltimore City, Maryland   |  |   |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br>Stephen S. Radentz, M.D.   |  | 29c. License number<br>O.C.M.E.  |  | 29d. Date signed (Month, Day, Year)<br>FEBRUARY 21, 1997  |  |
| State Registrar   | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br>Stephen S. Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201   |  |   |  |  |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br>FEB 28 1997  |  | 32. Registrar's Signature<br>John Davidson-Rendall  |  |  |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06049

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EVELYN SENNETT

2. Date of Death

Month Day Year  
FEBRUARY 25, 1996 12:52PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

212-18-6886

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 24, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Hillendale

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1108 Pelham Wood Road

10f. Zip Code

21234

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Salesperson

16b. Kind of Business/Industry

The Hecht Company

17. Father's Name (First, Middle, Last)

Isaac West

18. Mother's Name (First, Middle, Maiden Surname)

Mae Jackson

19a. Informant's Name/Relationship (Type, Print)

Mrs. Elaine D. Rice / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4459 Fenor Road Baltimore, MD 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Memorial Park

Date

3/1/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

► Mark T. Z...

22. Name and Address of Facility

5305 Harford Road  
Leonard J. Ruck, Inc. Baltimore, MD 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia

Due to (or as a consequence of):

b. Chronic Lymphocytic Leukemia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Week

10 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► James A. Davidson - M.D.

29c. License number

D 15561

29d. Date signed (Month, Day, Year)

2/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James A. Davidson, M.D. 7401 Oster Ave, Balto, MD 21204

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Registrar or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, the interpretation of the data, and the conclusions drawn from the research.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the limitations of the research, the strengths of the findings, and the suggestions for further research.

5. The fifth part of the report is a summary of the study. It includes a brief overview of the main findings and the conclusions drawn from the research.

6. The sixth part of the report is a list of references. It includes a list of the books, articles, and other sources used in the study.

7. The seventh part of the report is an appendix. It includes a list of the tables, figures, and other supplementary material used in the study.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item 24a 2-28-97 Film G744 W.H. Per Doctor State of Maryland / Department of Health and Mental Hygiene

97 06050

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Kathleen Keckner Snellings

2. Date of Death

Month Day Year  
Feb. 22 1997

3. Time of Death

8:45 AM

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

212-40-8171

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

54

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 29 1942

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7124 Heathfield Rd.

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (14 or 5+)  
4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Allen L. Keckner

18. Mother's Name (First, Middle, Maiden Surname)

Flora B. Barber

19a. Informant's Name/Relationship (Type, Print)

Albert L. Snellings

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

28 Alleghany Ave., #2512, Towson, MD 21204

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

2/24/97

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

Lowell M. Lemmon

22. Name and Address of Facility

Lemmon Funeral Home

10 W. Padonia Rd., Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Glio blastoma Multiforme*  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. \_\_\_\_\_  
Due to (or as a consequence of):c. \_\_\_\_\_  
Due to (or as a consequence of):d. \_\_\_\_\_  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alan J. Baldanza, M.D.

29c. License number

D 19166

29d. Date signed (Month, Day, Year)

2/24/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Alan J. Baldanza, M.D.

10629 York Rd., Cockeysville, MD 21030

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 06051

|  |   |  |  |   |  |
|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>AGNES SCHRUEFER</b>  |  | 2. Date of Death<br>Month <b>FEB</b> Day <b>23</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>1:05 PM</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>GOOD SAMARITAN HOSPITAL</b>  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |   | 4c. County of Death<br><b>—</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-34-9237</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.   | If Under 1 Year<br>Months Days                            | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>SEPT 24, 1905</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |  | 10a. State<br><b>MD.</b>   |   | 10b. County<br><b>Baltimore</b>  |
|  | 10c. City, Town or Location<br><b>Parkville</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
|  | 10e. Street and Number<br><b>7816 Old Harford Rd.</b>   |  | 10f. Zip Code<br><b>21234</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)                        |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEWIFE</b>  |
|  | 16b. Kind of Business/Industry<br><b>Home</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>George Schultz</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Cecilia Reinker</b>  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Charles Schrufer / son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1331 Chippen Dale Rd. LUTHERVILLE Md 21093</b> |   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Evans Funeral Chapel Bel Air</b>                                      |   | Date<br><b>Feb 26 1997</b>   |
|  | 20c. Location - City or Town, State<br><b>Forest Hill, Md.</b>  |  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   | 22. Name and Address of Facility<br><b>Evans Chapel of Memories 8800 Harford Rd</b>  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                             |  |  |   |  |
| Physician<br>/Medical<br>Examiner  | Immediate Cause (Final disease or condition resulting in death)   |  |  |   | Approximate Interval Between Onset and Death   |
|  | a. <b>MYOCARDIAL INFARCTION</b>   |  |  |   | <b>3 HOURS</b>   |
|  | Due to (or as a consequence of):  |  |  |   |  |
|  | b. <b>ACUTE RENAL FAILURE</b>   |  |  |   |  |
|  | Due to (or as a consequence of):  |  |  |   |  |
|  | c. <b>ACIDOSIS</b>  |  |  |   |  |
|  | Due to (or as a consequence of):  |  |  |   |  |
|  | d.  |  |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                      |  |  |   |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No            |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>                           |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred  |  |   |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |   |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i> <b>M.A.</b>  |   | 29c. License number<br><b>P10582</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>FEB 23 1997</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ANN MECHERIKUNNEL, 5601, LOCH RAVEN BLVD., BALTIMORE, MD-21239</b>  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 28 1997</b>  |   | 32. Registrar's Signature<br><i>[Signature]</i>                              |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06052

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>John W. Scaletta   |  |   |  | 2. Date of Death<br>Month Day Year<br>February 26, 1997  |  | 3. Time of Death<br>2:30 AM                                      |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br>Golden Oaks Nursing Home   |  |   |  | 4b. City, Town, or Location of Death<br>Laurel   |  | 4c. County of Death<br>Prince George                             |  |
| Funeral<br>Director                           | 5. Social Security Number<br>216-22-5001   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>69 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Feb. 22, 1928             |  |
|   | 9. Birthplace (State or Foreign Country)<br>Pennsylvania   |  | 10a. State<br>MD  |  | 10b. County<br>Prince George   |  | 10c. City, Town or Location<br>Laurel                            |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>7201 Donston Drive  |  | 10f. Zip Code<br>20707   |  | 10g. Citizen of What Country?<br>USA                             |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: 1946-1948 |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (14 or 5+) 0   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Service Technician                             |  | 16b. Kind of Business/Industry<br>Printing   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Anthony A. Scaletta   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Sara Agnes Gardener   |  |  |  |
| Physician<br>/Medical<br>Examiner             | 19a. Informant's Name/Relationship (Type, Print)<br>Michael Scaletta/Son   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>15715 Riding Stable Road, Laurel, Maryland 20707  |  |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Baltimore Washington Cr.  |  | Date<br>2/28   |  | 20c. Location - City or Town, State<br>Laurel, Maryland          |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br>Fleck Funeral Home, Inc.<br>7601 Sandy Spring Road, Laurel, Maryland 20707   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. Sepsis<br>Due to (or as a consequence of):<br>b. Recurrent Pneumonia<br>Due to (or as a consequence of):<br>c. Chronic Obstructive Pulmonary Disease<br>Due to (or as a consequence of):<br>d. Carcinoma Larynx<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |  |  |
|   | 28a. Date of Injury (Month, Day, Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br>D24035  |  | 29d. Date signed (Month, Day, Year)<br>2/27/97                   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>ES MACHADO 321 PRINCE GEORGE ST LAUREL MD 20707  |  |   |  |  |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>FEB 28 1997   |  |   |  | 32. Registrar's Signature<br>  |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06053

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SHIELDS, ANNIE

2. Date of Death

Month 2 Day 26 Year 97

3. Time of Death

8:15am

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

228-24-1769

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year

July 13, 1925

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3306 Devonshire Drive

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dietary Worker

16b. Kind of Business/Industry

Garrison Forest School

17. Father's Name (First, Middle, Last)

James Bunting

18. Mother's Name (First, Middle, Maiden Surname)

Ellen Mears

19a. Informant's Name/Relationship (Type, Print)

Arthur Shields /husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3306 Devonshire Drive Baltimore, MD. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland National

Date

3/4

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

Kevin Parker

22. Name and Address of Facility

Kevin A. Parker Funeral Home  
3512 Frederick Ave. Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Meningitis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

3 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral vascular disease

Gangrene of lower extremities

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Nicholas Ahn

29c. License number

AS2402321/NA/8509

29d. Date signed (Month, Day, Year)

February 26 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

NICHOLAS AHN, M.D., SINAI HOSPITAL, BALTIMORE, MARYLAND

31. Date filed (Month, Day, Year)

Feb 28 1997

32. Registrar's Signature

Nicholas Ahn

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Autopsy Facility: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: This certificate has been signed by the attending physician and completely filled in the funeral director, page 2 should be detached for use as the burial-transit form.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06054

|  |   |                              |   |   |  |  |  |  |
|--|---|------------------------------|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Annie SIMKIN</b>   |                              |   |   | 2. Date of Death<br>Month Day Year<br><b>Feb 21 1997</b>   |  | 3. Time of Death<br><b>1500 hrs</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Howard County General Hospital</b> |                              |   |   | 4b. City, Town, or Location of Death<br><b>Columbia</b>  |  | 4c. County of Death<br><b>Howard</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-56-9344</b>   |                              | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>94</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 5, 1902</b>                                     |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Russia</b>   |                              |   |   |  |  |  |  |
| Usual Residence of Decedent  |   |                              |   |   |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Howard</b> |   | 10c. City, Town or Location<br><b>Clarksville</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>11940 Hall Shop Road</b>  |   |                              |   | 10f. Zip Code<br><b>21029</b>   |  | 10g. Citizen of What Country?<br><b>Canadian</b>                             |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |                              | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th Grade</b><br>College (14 or 5+) <b>College</b>   |   |                              |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>   |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Hershel Kahansky</b>   |   |                              |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sarah Kahansky</b>  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Rita Adler</b>   |   |                              |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9760 Summer Park Court, Columbia, Maryland 21046</b>  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |                              | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mount Lebanon Cemetery</b>   |   |  | 20c. Location - City or Town, State<br><b>Adelphi, Maryland</b>              |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Donald C. Stettin</b>  |   |                              |   | 22. Name and Address of Facility<br><b>STEIN HEBREW MEMORIAL FUNERAL HOME, INC.<br/>232 CARROLL STREET, N.W., WASHINGTON, D.C. 20012</b>  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Biliary Adenocarcinoma</b><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><br>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |                              |   |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                              |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   |                              | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |  |
| 28d. Describe how injury occurred  |   |                              |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |                              |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br><b>MD</b>   |   |                              |   | 29c. License number<br><b>D42187</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>Feb 21, 1997</b>                   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JAMES DAY 11055 Little Patuxent Parkway Columbia MD 21045</b>   |   |                              |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 28 1997</b>  |   |                              |   | 32. Registrar's Signature<br><b>John Davidson-Randall</b>   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06055

DHHM 16 Rev 6/95

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**State  
Registrar**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Item: 23 part II per MEO G-746 4/1/97 reb reb  
Items: 23 part I, 27 per MEO G-745 3/11/97 Certificate of Death

97 06056

Reg. No.

|   |   |  |   |  |  |   |   |
|---|---|--|---|--|--|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>RODNEY WAYNE TUNSTALL</b>  |  |   | 2. Date of Death<br>Month <b>FEB.</b> Day <b>23</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>12:44 PM</b>   |   |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>HARBOR HOSPITAL</b>  |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>NA</b>  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>083-50-0863</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>31</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>5-25-65</b>                   |
|   | 9. Birthplace (State or Foreign Country)<br><b>New York</b>   |  |   |  |  |   |   |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |
|   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Glen Burnie</b>  |   |   |
|   | 10e. Street and Number<br><b>6416 B. Centennial Circle</b>  |  |   | 10f. Zip Code<br><b>21061</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (14 or 5+) <b>NA</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>                       |  | 16b. Kind of Business/Industry<br><b>Painter</b>   |   |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Leroy Tunstall</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Kathryn Tunstall</b>   |  |   |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Sharnelle Marshall</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6416 B Centennial Circle Glen Burnie, MD 21061</b> |  |   |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Glen Haren Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>3/1/97 Glen Burnie, MD</b>   |   |   |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   | 22. Name and Address of Facility<br><b>Albert P. Wylie F.H., PA<br/>638 N. Gilman St. Baltimore, MD 21217</b>  |  |   |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. CHRONIC RENAL FAILURE</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |  |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>PNEUMONIA</b>  |   |  |   |  |  |   |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |   |  |  |   |   |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   |  |  |   |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   |  |  |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |  |   |   |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |   |  |  |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year) |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   | 28d. Describe how injury occurred  |  |   |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |  |   |   |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |  |   |   |
| 29b. Signature and title of certifier<br>   |   |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>FEB. 24, 1997</b>  |   |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>J. Alon Locke, MD 111 Penn Street, Baltimore, Maryland 21201</b>   |   |  |   |  |  |   |   |
| 31. Date (Month, Day, Year)<br><b>FEB 27 1997</b>   |   |  | 32. Registrar's Signature<br>   |  |  |   |   |



97 06057

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Glenn Taylor</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 21 1997</b>   |  | 3. TIME OF DEATH<br><b>0915 AM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-68-5461</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>40</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>61/15/1957</b>                          |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Balto - md.</b>   |  |  |  |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Johns Hopkins Bayview</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Hartford</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Edgewood</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>2014 Brown Street</b>   |  |  |  | 10f. ZIP CODE<br><b>21040</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>           |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12<sup>th</sup> grade</b><br>College (1-4 or 5+) <b></b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Medical Transportation Clerk</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Medical Field</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John S. TAYLOR</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Thelma TAYLOR Crawford</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Christine TAYLOR</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>505 Meadowood drive, Edgewood md 21040</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>  |  | 20c. DATE<br><b>2/22</b>  |  | 20d. LOCATION — City or Town, State<br><b>Catonsville, md.</b>                       |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joseph R. Walton Jr.</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Unity Funeral Home<br/>105 W. North Ave., 21201</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Wasting Syndrome</b>   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |  |  |   |  |  |  |
| b. <b>Acquired Immuno deficiency Syndrome</b>  |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| c. <b>Mycobacterium Avium Complex, disseminated</b>  |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| d. <b></b>   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Timothy R. Sterling, MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>P 10755</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/25/97</b>                                |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Timothy R Sterling Ross Bldg Rm1159 720 Rutland Ave Baltimore, MD 21205</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 28 1997</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06058

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Helen Thrappas

2. Date of Death

Month Day Year  
Feb. 24, 1997

3. Time of Death

6:00pm

4a. Facility Name (If not institution, give street and number)

7808 St. Bridget Lane

4b. City, Town, or Location of Death

North Point

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

220-20-3987

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

April 27, 1930 Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

North Point

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7808 St. Bridget Lane

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8 yrs.

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Communications

16b. Kind of Business/Industry

Western Electric

17. Father's Name (First, Middle, Last)

George H. Jorgensen

18. Mother's Name (First, Middle, Maiden Surname)

Anna Charlett

19a. Informant's Name/Relationship (Type, Print)

James Thrappas husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7808 St. Bridget Lane Balto. Md. 21222

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory

Date

2-27

20c. Location - City or Town, State

Baltimore

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Connolly Funeral Home Of Dundalk  
7110 Sollers Point Rd. 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Due to (or as a consequence of):

Lung Cancer

Approximate  
Interval Between  
Onset and Death

11 months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D30929

29d. Date signed (Month, Day, Year)

2/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Celano, MD 6565 N. Charles St, Baltimore, MD 21204

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 69760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use on the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06059

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rufus Waller Sr.

2. Date of Death

Month

Day

Year

2 25 97

3. Time of Death

10:30 a.m.

4a. Facility Name (If not institution, give street and number)

213 S. Parrish St.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

214-58-8878

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs, last birthday)

46 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

10-31-50

9. Birthplace (State or Foreign Country)

Baltimore, MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

213 S. Parrish St.

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (14 or 5+)

0 NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Harold Prince Edward Waller

18. Mother's Name (First, Middle, Maiden Surname)

Maggie Waller

19a. Informant's Name/Relationship (Type, Print)

Berletha Waller-wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

213 S. Parrish St. Baltimore MD 21223

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Cemetery

Date

2-28-97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Albert P. Wylie F.H.P.A.  
638 N. Gilmore St. Baltimore MD 21217

Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HE10 MYO SARCOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Approximate interval between Onset and Death

9 mo

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 8 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D32263

29d. Date signed (Month, Day, Year)

2/25/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1940 West Baltimore St. Balt Md 21223

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director. page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06060

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Mary Warzecha

2. Date of Death

February 27, 1997

3. Time of Death

7<sup>00</sup> AMFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Potomac Valley Nursing Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

174-40-4731

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

Sept. 6, 1906

9. Birthplace (State or Foreign Country)

Ireland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

1235 Potomac Valley Road

10f. Zip Code

20850

10g. Citizen of What Country?

United Kingdom

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nanny

16b. Kind of Business/Industry

Child Care

17. Father's Name (First, Middle, Last)

(Unavailable) Pringle

18. Mother's Name (First, Middle, Maiden Surname)

Jane Ann Fowler

19a. Informant's Name/Relationship (Type, Print)

Janice R. Bishop/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10716 St. Paul Street, Kensington, Maryland 20895

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Washington Cr.

Date

2/27

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleck Funeral Home, Inc.

7601 Sandy Spring Road, Laurel, Maryland 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Merlyn Vemury

29c. License number

D35791

29d. Date signed (Month, Day, Year)

2/27/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MERLYN VEMURY MD 9801 GEORGIA AVE, SILVER SPRING MD 20902

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

J. A. Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 900-688-6888.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06061

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carl Francis Wallace

2. Date of Death

February 23 1997 10:35 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Church Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

218-26-2420

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

May 12, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

113 E. Lake Ave.

10f. Zip Code

21212

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

general contractor

16b. Kind of Business/Industry

construction

17. Father's Name (First, Middle, Last)

William Frederick Wallace

18. Mother's Name (First, Middle, Maiden Surname)

Estelle Petersen

19a. Informant's Name/Relationship (Type, Print)

Marian Wallace/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

113 E. Lake Ave. Baltimore, MD 21212

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount Crematory

Date

2/26/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

John D. Mitchell IV

22. Name and Address of Facility

Mitchell-Wiedefeld Home, Inc.  
6500 York Rd.  
Baltimore, MD 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multi-infarct Dementia

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Chronic Atrial Fibrillation

Due to (or as a consequence of):

d. Cerebrovascular Disease

Approximate Interval Between Onset and Death

3 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Prostate Cancer, Abdominal Aortic Aneurysm

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Vinicio Hernandez, MD

29c. License number

D46683

29d. Date signed (Month, Day, Year)

February 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vinicio Hernandez M.D. 101 N. Bond St. Baltimore, MD 21231

31. Date filed (Month, Day, Year)

FEB 28 1997

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06062

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY K. ANDERSON FEBRUARY 27 1997 6:51 AM

2. Date of Death  
Month Day Year

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

099-20-3708

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Sept. 26, 1924

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George

10c. City, Town or Location

Mitchellville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2105 Crepe Ct

10f. Zip Code

20721

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

I Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Church of God

17. Father's Name (First, Middle, Last)

James Harris

18. Mother's Name (First, Middle, Maiden Surname)

Loretta Bradley

19a. Informant's Name/Relationship (Type, Print)

ELAINE CUBY / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2105 Crepe Ct. Mitchellville, Md 20721

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland National Mem. Pl. 3/2/97 Laurel Maryland

Date

3/2/97

20c. Location - City or Town, State

Laurel Maryland

21. Signature of Funeral Service Licensee

Guy Hume

22. Name and Address of Facility

CHATMAN - NORRIS E.H.  
5240 REISTERSTOWN ROAD  
BALTIMORE, Maryland 21215

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. ASPIRATION PNEUMONIA

Approximate Interval Between Onset and Death

u8hr

Due to (or as a consequence of):

b. GASTROENTERITIS BLEEDING.

u 8hr.

Due to (or as a consequence of):

c. CEREBROVASCULAR ACCIDENT.

&gt; years.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia.

&gt; years

Decubetii

&gt; year

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 6 ☐ Could not be determined  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Guy Hume

29c. License number

D19609.

29d. Date signed (Month, Day, Year)

2-27-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAMAN R. TULI, MD 3503 PERRY STREET, MT. RAINIER, MD 20712.

31. Date filed (Month, Day, Year)

MAR 03 1997

32. Registrar's Signature

Julia Davidson-Rodale

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Coroner: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



MAR 01 1957

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06063

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

RICHARD LEE ADAMS

2. Date of Death

FEB. 18, 1997

3. Time of Death

8:10 PM

4a. Facility Name (If not institution, give street and number)

401 DORSEY AVE. APT. B1

4b. City, Town, or Location of Death

ESSEX

4c. County of Death

Baltimore

5. Social Security Number

213-28-0937

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 2, 1931

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

401 Dorsey Avenue Apt. B1

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes ☐ No  
If Yes, Give  
Year or Dates: 1950-5313. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

(unknown) Adams

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Ernest

19a. Informant's Name/Relationship (Type, Print)

Freida Zajdel (STEPSISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

329 Leeanne Road Essex, Md. 21221

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Greenmount Crematory 2/19/1997

Date

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Brudzinski Funeral Home P.A.

1407 Old Eastern Avenue Essex, Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes ☒ No25. Was case referred to medical  
examiner?☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

FEB. 19, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dennis Chute M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAR 03 1997

32. Registrar's Signature

Julie Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
document.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

9

Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06064

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth E. Beachum

2. Date of Death

February 28, 1997

3. Time of Death

1:00 A.M.

4a. Facility Name (If not institution, give street and number)

Manor Care Ruxton

4b. City, Town, or Location of Death

Ruxton

4c. County of Death

Baltimore

5. Social Security Number

217-12-3209A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

6-5-1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

110 Galewood Road

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Mercantile Safe Deposit  
& Trust Co.

17. Father's Name (First, Middle, Last)

Brinton Beachum

18. Mother's Name (First, Middle, Maiden Summa)

Edna Batchelor

19a. Informant's Name/Relationship (Type, Print)

Burt H. Bader (Brother In Law)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

110 Galewood Road, Timonium, Maryland 21093

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp.

Date

3-1-97

20c. Location - City or Town, State

Towson, Maryland 21204

21. Signature of Funeral Service Licensee

Wallace S. Brooke, Jr.

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.  
1050 York Road, Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

C.O.P.D.

Approximate Interval Between Onset and Death

75 years

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

342736

29d. Date signed (Month, Day, Year)

2-28-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ayman F. Akkad, M.D. 7600 Osler Drive, Towson, Maryland 21204

31. Date filed (Month, Day, Year)

MAR 03 1997

32. Registrar's Signature

John F. Rindell

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23c-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The information that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

7

State  
Registrar

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State of Maryland / Department of Health and Mental Hygiene

97 06065

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jean BIRD

2. Date of Death

March 2, 1997

3. Time of Death

6:55 a.m.

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

219-18-1245

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

08/14/1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8800 Walther Blvd.

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Edward E. Hargest

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Carson

19a. Informant's Name/Relationship (Type, Print)

Rebecca Heggemann/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5877 Bellanca Dr. Elkridge, Maryland 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Druid Ridge Cemetery

Date

03/05/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Michael J. Ruck

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Road Towson, Maryland 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Anoxic encephalopathy

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 days

b. Cardiac arrest

Due to (or as a consequence of):

c. Coronary artery disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician:2 ☐ Medical Examiner:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Paul Tecklenberg

29c. License number

D 14473

29d. Date signed (Month, Day, Year)

3-2-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Paul Tecklenberg

9000 Franklin Square Drive

Baltimore, Md. 21237

31. Date filed (Month, Day, Year)

MAR 03 1997

32. Registrar's Signature

John Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

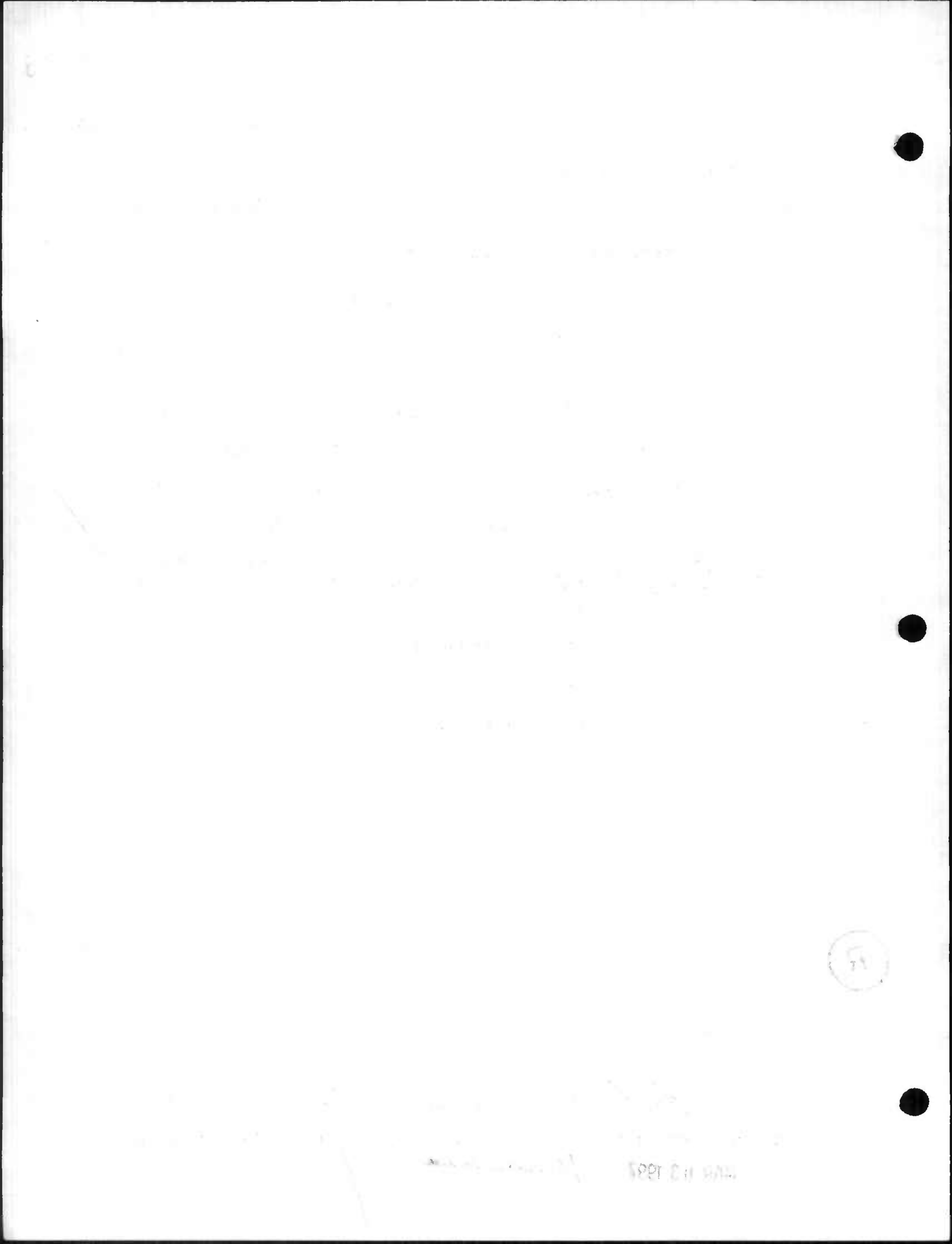
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



5

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06066

## Certificate of Death

Reg. No.

|   |   |  |  |  |   |  |   |  |
|---|---|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>BRIAN J. BEACOM</b>  |  |  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>1</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>12:29 AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>NORTH ARUNDEL HOSPITAL</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>GLEN BURNIE</b>  |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>220-90-7482</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>29</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 15 1967</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>PENNSYLVANIA</b>   |  | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>ANNE ARUNDEL</b>  |  | 10c. City, Town or Location<br><b>GLEN BURNIE</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>215 SCOTTS MANOR DRIVE</b>  |  | 10f. Zip Code<br><b>21061</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Backhoe Operator</b>   |  | 16b. Kind of Business/Industry<br><b>Heavy Equipment</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>THOMAS R. BEACOM</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SHIRLEY J. BETUSH</b>  |  | 19. Informant's Name/Relationship (Type, Print)<br><b>SHIRLEY J. BEACOM - mother</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8131 OAKWOOD ROAD GLEN BURNIE, MARYLAND 21061</b> |  |
| Physician<br>/Medical<br>Examiner             | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GLEN HAVEN CEMETERY</b>   |  | 20c. Date<br><b>3/4/1997</b>  |  | 20d. Location - City or Town, State<br><b>GLEN BURNIE, MARYLAND</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Hilary L. Stallings, J.C.</b>   |  | 22. Name and Address of Facility<br><b>STALLINGS FUNERAL HOME P.A.<br/>3111 Mountain road Pasadena, Maryland 21122</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Multiple Injuries</b>                                   |  | Approximate Interval Between Onset and Death  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No    |  |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)<br><b>3-1-97</b>   |  |
| To Be Completed by Physician/Medical Examiner | 28b. Time of Injury<br><b>0002</b> M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><b>Pedestrian struck by vehicle</b>  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>STREET</b>   |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Mountain Road 21122</b>  |  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Dr. Lawrence</b>  |  | 29c. License number<br><b>O.C.M.E</b>   |  |
| State Registrar                               | 29d. Date signed (Month, Day, Year)<br><b>MARCH 2, 1997</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. LA RON WICK, MD 111 Penn Street, Baltimore, Maryland 21201</b>   |  | 31. Date filed (Month, Day, Year)<br><b>MAR 03 1997</b>   |  | 32. Registrar's Signature<br><b>J. LaRon Wick</b>   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Items: 23 part I, 27, 28a, b, c, d, e, f per MEO G-74 3/11/97 rep

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>ROBERT L. BENTZ  |  |   |  | 2. Date of Death<br>Month Day Year<br>FEBRUARY 26, 1997  |  | 3. Time of Death<br>1:15 P.M.  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>FRANKLIN SQUARE HOSPITAL   |  |   |  | 4b. City, Town, or Location of Death<br>ESSEX  |  | 4c. County of Death<br>BALTIMORE   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>217 58 8954   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>33 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>July 22, 1963   |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland   |  | 10. Usual Residence of Decedent<br>10a. State<br>maryland   |  | 10b. County<br>Howard  |  | 10c. City, Town or Location<br>Ellicott City   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>3041 Hickory Mede Ct.   |  | 10f. Zip Code<br>21042   |  | 10g. Citizen of What Country?<br>Untied States   |  |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Electrician  |  | 16b. Kind of Business/Industry<br>Building Construction  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Robert E. Lee Bentz   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lucy M. Tana  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Lucy M. Bentz / mother   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3041 Hickory Mede Ct., Ellicott City, MD 21042  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Green Mount Crematory   |  | 20c. Location - City or Town, State<br>Baltimore, MD   |  | 20d. Date<br>3/1/97  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><i>Stephen D. Lohrmann</i>  |  |   |  | 22. Name and Address of Facility<br>CAFA Stephen D. Lohrmann P.A.<br>8717 Green Pastures Dr., Baltimore, MD 21286  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |  |
| To Be Completed by Physician/Medical Examiner | 24. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation<br>6 <input checked="" type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)<br>FOUND 2/26/97   |  | 28b. Time of Injury<br>FOUND 12:55   |  |
|   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br>Unknown  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br>Unknown  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Franklin Square Emergency Room |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                    |  |   |  | 29b. Signature and title of certifier<br><i>Theodore M. King</i>   |  | 29c. License number<br>O.C.M.E.  |  |
|   | 29d. Date signed (Month, Day, Year)<br>FEBRUARY 27, 1997   |  | 29e. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Theodore M. King</i><br>111 Penn Street, Baltimore, Maryland 21201  |  | 29f. Date filed (Month, Day, Year)<br>MAR 03 1997  |  | 29g. Registrar's Signature<br><i>John Davidson-Rodell</i>  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06068

Item 1 per PHY. Film G745 3-3-97 rja

## Certificate of Death

Reg. No.

|   |   |   |   |                                       |  |  |
|---|---|---|---|---------------------------------------|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>THOMAS E. CROW, JR.</b>  |   | 2. Date of Death<br>Month Day Year<br><b>FEB. 13, 1997</b>  |                                       | 3. Time of Death<br><b>6:12 AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SAINT JOSEPH MEDICAL CENTER</b>  |   | 4b. City, Town, or Location of Death<br><b>TOWSON</b>   |                                       | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-28-9426</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.  | If Under 1 Year<br>Months Days        | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>8-7-1931</b> |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   |   |                                       |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |   | 10a. State<br><b>Maryland</b>   |                                       | 10b. County<br><b>Baltimore</b>  |  |
|   | 10c. City, Town or Location<br><b>Towson</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                       |  |  |
|   | 10e. Street and Number<br><b>8415 Bellona Lane, Apt. 512</b>  |   | 10f. Zip Code<br><b>21204</b>   |                                       | 10g. Citizen of What Country?<br><b>U. S. A.</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Korean</b> |                                       | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+) <b>4</b>                             |                                       | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Manager, Legal Dept.</b>  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Thomas E. Crow, Sr.</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Harper</b>   |                                       | 19. Informant's Name/Relationship (Type, Print)<br><b>Mrs Elizabeth G. Crow (Wife)</b>   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)           |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Mem. Gards</b>  |                                       | 20c. Location - City or Town, State<br><b>2-15-97 Timonium, Maryland</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Wallace S Brooks Jr.</b>  |   | 22. Name and Address of Facility<br><b>1050 York Rd. Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>   |                                       |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>ACUTE MYOCARDIAL INFARCTION</b> |   | Due to (or as a consequence of):<br><b>CORONARY ARTERY DISEASE</b>  |                                       | Approximate Interval Between Onset and Death   |  |
|   | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>CONGESTIVE HEART FAILURE</b>  |   | Due to (or as a consequence of):  |                                       |  |  |
| Due to (or as a consequence of):  |   |   |   |                                       |  |  |
| Due to (or as a consequence of):  |   |   |   |                                       |  |  |
| Due to (or as a consequence of):  |   |   |   |                                       |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CONGESTIVE HEART FAILURE</b>   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |                                       |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                                       |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                                       |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>       |  |  |
| 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred   |   |                                       |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |                                       |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>Boon P. Lim</b>   |   | 29c. License number<br><b>D 37254</b> |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>2-13-97</b>   |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BOON P. LIM, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204</b>  |   |                                       |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 03 1997</b>   |   | Registrar's Signature<br><b>John Davidson</b>   |   |                                       |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RECEIVED

APR 9 1951

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item 18 3-3-97 Film G745 W.H. Per F/H State of Maryland / Department of Health and Mental Hygiene

97 06069

## Certificate of Death

Reg. No.

|  |  |   |   |  |  |  |  |                                   |  |
|--|--|---|---|--|--|--|--|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedant's Name (First, Middle, Last)<br>JOHN ROGER COX   |   |   |  | 2. Date of Death<br>Month Day Year<br>February 28, 1997  |  | 3. Time of Death<br>6:35 AM  |                                   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>7414 Monita Rd.  |   |   |  | 4b. City, Town, or Location of Death<br>Pikesville   |  | 4c. County of Death<br>Baltimore   |                                   |  |
| Funeral<br>Director  | 5. Social Security Number<br>220-38-9777   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>54 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Sept. 13, 1942  |                                   |  |
|  | Usual Residence of Decedant<br>10a. State<br>Maryland  |   | 10b. County<br>Baltimore Co.  |  | 10c. City, Town or Location<br>Pikesville  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                   |  |
| To Be Completed by Funeral Director  | 10e. Street and Number<br>7414 Monita Road   |   |   |  | 10f. Zip Code<br>21208   |  | 10g. Citizen of What Country?<br>United States   |                                   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedant Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: Vietnam |  | 13. Was Decedant of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |                                   |  |
|  | 15. Decedant's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 04   |   | 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Computer Analyst                                 |  | 16b. Kind of Business/Industry<br>MTA Public Transportation  |  |  |                                   |  |
|  | 17. Father's Name (First, Middle, Last)<br>John Cox  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><del>Pauline James</del> Bessie Pauline Richards  |  |  |                                   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Monica R. (nee Fike) Cox (Wife)   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7414 Monita Road Pikesville, Md. 21208  |  |  |                                   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Garrison Forest Vet. Cem.   |  | 20c. Location - City or Town, State<br>3/04/97 Owings Mills, Maryland  |  |  |                                   |  |
|  | 21. Signature of Funeral Service Licensee<br>Jeffrey L. Gair   |   |   |  | 22. Name and Address of Facility<br>Ruck Towson Funeral Home, Inc.<br>1050 York Rd. Towson, Md. 21204  |  |  |                                   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>e. Coronary Artery Disease<br>Due to (or as a consequence of):<br><br>f. Due to (or as a consequence of):<br><br>g. Due to (or as a consequence of):<br><br>h. Due to (or as a consequence of): |   |   |  | Approximate Interval Between Onset and Death<br>Years  |  |  |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |                                   |  |
|  |  |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                                   |  |
|  |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |                                   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |                                   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M                       |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |                                   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier   |   |  |  |  |  |                                   |  |
|  |  | 29c. License number<br>D33475   |   | 29d. Date signed (Month, Day, Year)<br>2-28-97 |  |  |  |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>David Zimrin, M.D. 1838 Greene Tree Rd. Baltimore, Md. 21208   |  |   |   |  |  |  |  |                                   |  |
| 31. Date filed (Month, Day, Year)<br>MAR 03 1997   |  | 32. Registrar's Signature<br>John Davidson-Rendell  |   |  |  |  |  |                                   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or attending physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: This certificate has been signed by the attending physician and completely filed by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06070

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gertrude T. Chase

2. Date of Death

March 2, 1997 12 02 AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

2629 N. Hilton Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

215-24-8274

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

February 20, 1908

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2629 N. Hilton Street

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Dietician

16b. Kind of Business/Industry

Food

17. Father's Name (First, Middle, Last)

Sam Thornton

18. Mother's Name (First, Middle, Maiden Surname)

Anna Jones

19a. Informant's Name/Relationship (Type, Print)

Barbara Gray

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2629 N. Hilton Street, Baltimore, Maryland 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

Date

March 7, 1997

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Carlton C. Douglas

22. Name and Address of Facility

Carlton C. Douglass Funeral Service, 1701 McCulloh Street, Baltimore, Maryland 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cancer of the Uterine Cervix, metastatic

Approximate Interval Between Onset and Death

1 yr.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. J. L. Gumbel MD

29c. License number

D-12550

29d. Date signed (Month, Day, Year)

3/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7801 York Rd Towson, Md 21286

31. Date filed (Month, Day, Year)

MAR 03 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Handwritten signature or initials.

NOV 07 1983


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06071

## Certificate of Death

Reg. No.

|   |  |   |  |  |  |   |  |  |
|---|--|---|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>LILA R. CHRISTNER</b>                                     |   |  |  | 2. Date of Death<br>Month <b>02</b> Day <b>28</b> Year <b>1997</b> |   | 3. Time of Death<br><b>2:50 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SHOCK TRAUMA / UNIVERSITY OF MD</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>           |   | 4c. County of Death<br><b>BALTIMORE CITY</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>282-50-6424</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>45</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                                     | 8. Date of Birth (Month, Day, Year)<br><b>July 13, 1951</b>                                 |  | 9. Birthplace (State or Foreign Country)<br><b>VA</b>  |
|   | Usual Residence of Decedent  |   |  |  |  |   |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>2009 Eagle Street</b>  |  |   |  | 10f. Zip Code<br><b>21223</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> Collage (1-4or 5+) <b></b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Home Maker</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Bernard Kilgore</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lela Sulfridge</b>   |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Bernard Kilgore/Father</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>45381 1375 N. Sulphur Springs Rd W. Alexandria, OH</b>                                   |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington Cemetery</b>   |  | Date<br><b>March 5, 1997</b>   |  | 20c. Location - City or Town, State<br><b>Brookville, OH</b>                                |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Sterling Ashton Funeral Home, Inc.<br/>736 Edmondson Avenue Catonsville, Md 21228</b>   |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ANOXIC ENCEPHALOPATHY</b><br>Due to (or as a consequence of):<br><b>b. HEAD INJURY</b><br>Due to (or as a consequence of):<br><b>c. FALL</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC ALCOHOL ABUSE</b>  |  |   |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>02-19-97</b>   |  | 28b. Time of Injury<br><b>UNK</b> M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred<br><b>FALL AT HOME</b>   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>H31298</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>02-28-97</b>                                      |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>KEVIN B. GEROLD, DO, SHOCK TRAUMA CENTER, BALTIMORE, MD 21201</b>  |  |   |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 03 1997</b>   |  | 32. Registrar's Signature<br>  |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Attending Physician: The law requires that the death certificate be executed without delay after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

RECEIVED - 1957

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MAR 10 1957

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State of Maryland / Department of Health and Mental Hygiene

97 06072

## Certificate of Death

Reg. No.

|   |   |  |   |   |   |                             |   |
|---|---|--|---|---|---|-----------------------------|---|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>TERESA MAE CHESTNUT   |  |   | 2. Date of Death<br>Month Day Year<br>FEBRUARY 27, 1997   |   | 3. Time of Death<br>16:30 P |   |
|   | 4a. Facility Name (If not institution, give street and number)<br>JOHN HOPKINS HOSPITAL   |  |   | 4b. City, Town, or Location of Death<br>BALTIMORE   |   | 4c. County of Death<br>N/A  |   |
| Funeral<br>Director                           | 5. Social Security Number<br>216-68-7377  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>38 Yrs.   |                             | 8. Date of Birth (Month, Day, Year)<br>10-13-58   |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland  |  | 10a. State<br>Md.   |   | 10b. County<br>N/A  |                             | 10c. City, Town or Location<br>Baltimore  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br>19 S. Monastery Avenue  |   | 10f. Zip Code<br>21229  |                             | 10g. Citizen of What Country?<br>U.S.A.   |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                             | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>BS Degree   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Postal Clerk                             |   | 16b. Kind of Business/Industry<br>United States Postal Service  |                             |   |
|   | 17. Father's Name (First, Middle, Last)<br>David Chestnut   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ella M. Stokes   |   |                             |   |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Gwendolyn Winston   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2109 Mt. Holly Street, Baltimore, Maryland 21216   |   |                             |   |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>David Ridge Cemetery  |   | 20c. Location - City or Town, State<br>Pikesville, Maryland   |                             |   |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |   | 22. Name and Address of Facility<br>Joseph H. Brown Jr. Funeral Home<br>2140 N. Fulton Avenue, Baltimore, Maryland 21217  |   |                             |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Multiple Injuries<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown<br>24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |                             |   |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |   |                             |   |
|   | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br>2/26/97   |   | 28b. Time of Injury<br>0640 HR  |                             | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred<br>Subject driver, struck by vehicle  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>roadway   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>1200 61st Maryland Road, Baltimore, Maryland  |                             |   |
|   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   | 29b. Signature and title of certifier<br><i>Theodore M. King</i>  |   | 29c. License number<br>OCME |   |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)<br>FEBRUARY 27, 1997  |  |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Theodore M. King<br>111 Penn Street, Baltimore, Maryland 21201  |   |                             |   |
|   | 31. Date filed (Month, Day, Year)<br>MAR 03 1997  |  |   | 32. Registrar's Signature<br><i>[Signature]</i>   |   |                             |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

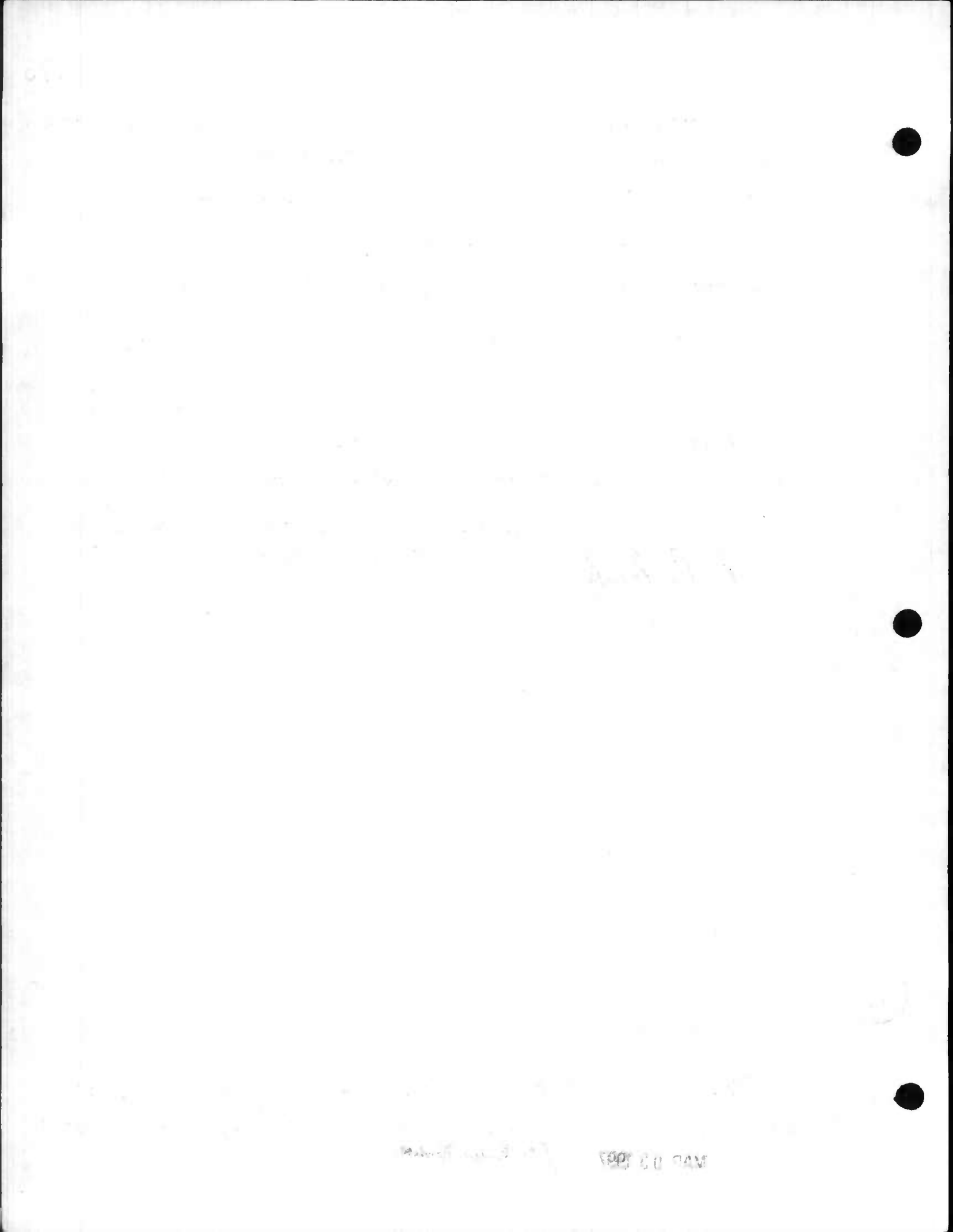
Reg. No.

97 06073

|   |   |  |   |                                |  |  |  |  |
|---|---|--|---|--------------------------------|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Charles L. Deinlein</b>  |  |   |                                |  | 2. Date of Death<br>Month Day Year<br><b>march 2, 1997</b>   |  | 3. Time of Death<br><b>5:45am</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Union Memorial Hospital</b>  |  |   |                                |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>  |  | 4c. County of Death<br><b>N/A</b>  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>216-28-4100</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>April 18, 1933</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|   | Usual Residence of Decedent   |  |   |                                |  |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Baltimore</b>  | 10c. City, Town or Location<br><b>Rosedale</b>  |                                |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
|   | 10e. Street and Number<br><b>5004 Hazelwood Avenue</b>  |  |   | 10f. Zip Code<br><b>21206</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1949-52</b>  |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>          |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Driver</b>  |                                |  | 16b. Kind of Business/Industry<br><b>Towing Company</b>  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>August Deinlein</b>   |  |   |                                |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marie Needer</b>   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Margaret Shirley Deinlein (WIFE)</b>   |  |   |                                |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5004 Hazelwood Ave. Baltimore, Md. 21206</b> |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holly Hill Mem. Gardens</b>  |                                | Date<br><b>3/5/1997</b>  | 20c. Location - City or Town, State<br><b>Baltimore Co., Md.</b>   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>John Burkowski</i>  |  | 22. Name and Address of Facility<br><b>Bruzdzinski Funeral Home P.A.<br/>1407 Old Eastern Avenue Essex, Md. 21221</b>   |                                |  |  |  |  |
| Physician<br>/Medical<br>Examiner             | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>e. <b>Lung Carcinoma</b><br>Due to (or as a consequence of):<br>b. <b>Pneumonia</b><br>Due to (or as a consequence of):<br>c. <b>Ischemic Cardiomyopathy</b><br>Due to (or as a consequence of):<br>d.           |  |   |                                |  |  |  | Approximate Interval Between Onset and Death<br><br><b>1 year</b><br><br><b>3 weeks</b><br><br><b>1 year</b>   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how Injury occurred   |                                |  |  |  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 28e. Date of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                                |  |  |  |  |
|   | 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>Erica Isles M.D.</i>  |                                | 29c. License number<br><b>AT2438946</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>march 2, 1997</b>                      |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Erica Isles, MD. 201 East University Parkway Baltimore MD 21218</b>  |  |   |                                |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>MAR 03 1997</b>   |  | 32. Registrar's Signature<br><i>John Burkowski</i>  |                                |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

97 06074

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anna N Emge

2. Date of Death

Month

Day

Year

3. Time of Death

4:30am

4a. Facility Name (If not institution, give street and number)

MARYLAND MANOR NURSING HOME

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

219-12-6530

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 9, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Reisterstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2225 Knox Ave.

10f. Zip Code

21136

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Homemaker

17. Father's Name (First, Middle, Last)

George Raymond Jackson

18. Mother's Name (First, Middle, Maiden Surname)

Addie Mae Baine

19a. Informant's Name/Relationship (Type, Print)

David Emge Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5102 Cynthia Ct., Baltimore, Md. 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evergreen Mem. Gardens 03/05/97

Date

20c. Location - City or Town, State

Finksburg, Md.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Eckhardt Funeral Chapel

11605 Reisterstown Rd., Owings Mills, Md. 21117

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Carcinoma of Breast

e.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

3 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



Attending Physician)

29c. License number

D14160

29d. Date signed (Month, Day, Year)

03/03/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225

31. Date filed (Month, Day, Year)

MAR 03 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Funeral Home: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06075

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |                                |   |  |  |  |
|---|--|--|---|--|---|--------------------------------|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>TRUMA ELLIOTT</b>   |  |   |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>28</b> Year <b>1997</b>  |                                |   |  | 3. Time of Death<br><b>0035</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>NORTHWEST HOSPITAL CENTER</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>RANDALLSTOWN</b>   |                                |   |  | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>216 74-7209</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>NOV. 7, 1915</b>                                  |  | 9. Birthplace (State or Foreign Country)<br><b>N. CAROLINA</b>   |  |
|   | Usual Residence of Decedent  |  |   |  | 10a. State<br><b>Maryland</b>   |                                | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Randallstown</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  | 10e. Street and Number<br><b>510 Shamrock Lane</b>  |                                | 10f. Zip Code<br><b>21208</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                     |  |  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TEACHER'S AIDE</b>  |                                | 16b. Kind of Business/Industry<br><b>Baltimore City Public Schools</b>                      |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Linwood Lawson</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Thaxie Smith</b>  |                                |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Opheelia Bell</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>510 Shamrock Lane Balt. Co Md 21208</b>   |                                |   |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lawson Chapel Baptist Church Cem</b>                                 |  | Date<br><b>3/6/97</b>   |                                | 20c. Location - City or Town, State<br><b>Roxboro, N.C.</b>                                 |  |  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Shana Adams</b>  |  |   |  | 22. Name and Address of Facility<br><b>W. Jones Jr. F.H.P.A. 4101 Edmondson Avenue 21227</b>  |                                |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>PULMONARY EMBOLISM</b>   |  |   |  |   |                                |   |  | Approximate Interval Between Onset and Death   |  |
| To Be Completed by Physician/Medical Examiner | Immediate Cause (Final disease or condition resulting in death)<br><b>PULMONARY EMBOLISM</b>   |  |   |  | Due to (or as a consequence of):  |                                |   |  |  |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>PULMONARY EMBOLISM</b>  |  |   |  | Due to (or as a consequence of):  |                                |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                |   |  |  |  |
|   |  |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA                       |  | Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |                                |   |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Harri Cotton</b>  |  | 29c. License number<br><b>D-08225</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 28, 1997</b>                             |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>NOLAN L. HORWITZ, M.D., NORTHWEST HOSPITAL CENTER, RANDALLSTOWN MD 21133</b>  |  |   |  |   |                                |   |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>MAR 03 1997</b>  |  | 32. Registrar's Signature<br><b>Julia Davidson-Roberts</b>  |  |   |                                |   |  |  |  |

SECRET

TOP SECRET

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06076

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rose Marie Greene

2. Date of Death

February 26 97

3. Time of Death

10:05 AM

4a. Facility Name (If not institution, give street and number)

Brightwood Center

4b. City, Town, or Location of Death

Rd Lutherville

4c. County of Death

Md.

Funeral  
Director

5. Social Security Number

216-42-5034

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

54

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 4, 1942

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5455 Bockwell Rd.

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Unemployment Specialist

16b. Kind of Business/Industry

Dept. of unemployment

17. Father's Name (First, Middle, Last)

Herbert Offer

18. Mother's Name (First, Middle, Maiden Surname)

Mary Williams

19a. Informant's Name/Relationship (Type, Print)

Marie Greene

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2102 Flinkshire Rd. apt 2 Balto 21237

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King mem Park

Date

3-3-97

20c. Location - City or Town, State

Randallstown Md.

21. Signature of Funeral Service Licensee

Dale March

22. Name and Address of Facility

March Funeral Home  
4300 Wabash Ave. Balto. Md. 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Carcinomatous

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

weeks

b.

Carcinoma of Breast

Due to (or as a consequence of):

months

c.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Malignant pleural effusion

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul Schwartz M.D. Medical Attending

29c. License number

D17118

29d. Date signed (Month, Day, Year)

2/27/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Schwartz M.D. 4000 Old Court Rd Suite 203 21208

31. Date filed (Month, Day, Year)

MAR 03 1997

32. Registrar's Signature

John B. [Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

The law requires that the death certificate be executed within 24 hours after death. To the Hospital Attending Physician: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

(11)

Handwritten signature

1981

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06077

## Certificate of Death

Reg. No.

|   |   |   |   |                                |  |
|---|---|---|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>DANIEL GREEN</b>   |   | 2. Date of Death<br>Month <b>2</b> Day <b>21</b> Year <b>97</b>   |                                | 3. Time of Death<br><b>12:35am</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>FOREST HAVEN NH</b>  |   | 4b. City, Town, or Location of Death<br><b>CATONSVILLE</b>  |                                | 4c. County of Death<br><b>BALTO.</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-54-3141</b>   | 8. Sex<br><b>M</b> <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>96</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|   | Usual Residence of Decedent   |   | 8. Date of Birth (Month, Day, Year)<br><b>1/1/01</b>  |                                | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   | 10b. County<br><b>BALTO.</b>                  | 10c. City, Town or Location<br><b>CATONSVILLE</b>   |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>315 INGLESIDE AVE</b>  |   | 10f. Zip Code<br><b>21228</b>   |                                | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>UNKNOWN</b> College (1-4or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LABORER</b>                       |                                | 16b. Kind of Business/Industry<br><b>LONGSHOREMAN</b>  |
|   | 17. Father's Name (First, Middle, Last)<br><b>UNKNOWN</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>UNKNOWN</b>   |                                |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lillian Sibeon - RH</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>315 INGLESIDE AVE BALTO., MD 21228</b>        |                                |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MT ZION CEM</b>  |                                | 20c. Location - City or Town, State<br><b>3/3/97 BALTO., MD</b>  |
|   | 21. Signature of Funeral Service Licensee<br><i>Calvin L. Williams</i>  |   | 22. Name and Address of Facility<br><b>270 Fred Hilton Pkss BALTO., MD</b>  |                                |  |
|   | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |                                |  |
|   | Immediate Cause (Final disease or condition resulting in death)<br><b>CEREBRAL THROMBOSIS</b><br>Due to (or as a consequence of):<br>a. _____<br>b. _____<br>c. _____<br>d. _____<br>{ Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |                                |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown<br>24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   |                                |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |   |   |                                |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide<br>28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |   |                                |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |   |                                |  |
| 29b. Signature and title of certifier<br><i>Dr. [Signature]</i><br>29c. License number<br><b>128595</b><br>29d. Date signed (Month, Day, Year)<br><b>3/21/97</b>  |   |   |   |                                |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>TASNEEM AKRAM, 7220 PARK HEIGHTS AVE BALTO MD 21208</b>  |   |   |   |                                |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 03 1997</b><br>32. Registrar's Signature<br><i>Julia Davidson-Randall</i>   |   |   |   |                                |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "nature", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

[illegible]

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06078

Items: 23 part I, 27 per ME0 G-746 4/1/97 reb

Reg. No.

|   |   |  |  |   |  |
|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JEFFREY MICHAEL HIGGINS</b>  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>1</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>1:48 P.M.</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>GREATER BALTIMORE MEDICAL CENTER</b>   |  | 4b. City, Town, or Location of Death<br><b>TOWSON</b>  |   | 4c. County of Death<br><b>BALTIMORE</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-08-2478</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>27</b> Yrs.   | If Under 1 Year<br>Months Days                              | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 29, 1969</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Baltimore, Md.</b>  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore Co.</b>  |   | 10c. City, Town or Location<br><b>Cockeysville</b>   |
|   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |
|   | 10e. Street and Number<br><b>6 Valley Crossing Circle</b>   |  | 10f. Zip Code<br><b>21030</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:        |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>01</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales Manager</b>                        |   | 16b. Kind of Business/Industry<br><b>Retail Sales</b>  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Michael Lee Higgins</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Kathleen Atkinson</b>   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print) (Mother)<br><b>Mary Kathleen (nee Atkinson) Higgins</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6 Valley Crossing Circle Cockeysville, Md. 21030</b> |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Mem. Gard.</b>   |   | Date<br><b>3/05/97</b>   |
|   | 20c. Location - City or Town, State<br><b>Timonium, Maryland</b>  |  |  |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Jeffrey L. Gair</b>   |   | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Road Towson, Md. 21204</b>   |  |   |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                              |  |  |   |  |
|   | Immediate Cause (Final disease or condition resulting in death)<br><b>ACUTE MYOCARDITIS</b>   |  |  |   |  |
|   | Due to (or as a consequence of):  |  |  |   |  |
|   | Due to (or as a consequence of):  |  |  |   |  |
|   | Due to (or as a consequence of):  |  |  |   |  |
|   | Due to (or as a consequence of):  |  |  |   |  |
|   | Due to (or as a consequence of):  |  |  |   |  |
|   | Due to (or as a consequence of):  |  |  |   |  |
|   | Due to (or as a consequence of):  |  |  |   |  |
|   | Due to (or as a consequence of):  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |  |  |   |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>                             |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   | 28d. Describe how injury occurred  |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |   |  |
| 29b. Signature and title of certifier<br><b>J. L. Larson</b>  |   | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 2, 1997</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. LARSON, MD 111 Penn Street, Baltimore, Maryland 21201</b>   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 03 1997</b>   |   |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06079

|  |  |   |  |  |  |   |   |  |
|--|--|---|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>August HINKE</b>  |   |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>1</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>6:30 a.m.</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital Center</b>   |   |  |  | 4b. City, Town, or Location of Death<br><b>Rosedale</b>  |   | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>151-01-0400</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>February 7, 1913</b>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>  |   | 10c. City, Town or Location<br><b>Rosedale</b>  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  | 10e. Street and Number<br><b>1504 Brian Road</b>   |   | 10f. Zip Code<br><b>21237</b>   |  |
|  | 10g. Citizen of What Country?<br><b>United States</b>  |   |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
|  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)                       |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Dye Maker</b>  |   |  |  | 16b. Kind of Business/Industry<br><b>Continental Can</b>   |   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>August Charles Hinke</b>   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jennie Erdman</b>  |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Margaret Ann Hinke / Wife</b>   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1504 Brian Road Baltimore, MD 21237</b>  |   |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>3/4/97 Baltimore, Maryland</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Brian A. Willem</b>  |   |  |  | 22. Name and Address of Facility<br><b>5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214</b>   |   |   |  |
|  | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. End stage metastatic lung cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |  |  | Approximate Interval Between Onset and Death<br><b>1 year</b>  |   |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred  |  |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |   |   |  |
| 29b. Signature and title of certifier<br><b>Prosper Sanchez, Medical Resident</b>  |  |   |  | 29c. License number<br><b>RD02124</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>March 1, 1997</b>                                 |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Prosper Sanchez 9000 Franklin Square Drive Baltimore, Md. 21237</b>   |  |   |  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 03 1997</b>  |  |   |  | 32. Registrar's Signature<br><b>Jane Davidson-Randall</b>  |  |   |   |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The last required signature for the death certificate to be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the report deals with the general situation of the country. It is a very interesting and informative study of the country's development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's development.

2. The second part of the report deals with the economic situation of the country. It is a very interesting and informative study of the country's economic development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's economic development.

3. The third part of the report deals with the social situation of the country. It is a very interesting and informative study of the country's social development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's social development.

4. The fourth part of the report deals with the political situation of the country. It is a very interesting and informative study of the country's political development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's political development.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06080

## Certificate of Death

Reg. No.

|  |   |  |  |  |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Delia Hunt  |  |  |  | 2. Date of Death<br>Month Day Year<br>March 3, 1997  |  |  |  | 3. Time of Death<br>4:45 am  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Riverview Nursing Centre 1 Eastern Blvd.  |  |  |  | 4b. City, Town, or Location of Death<br>Baltimore  |  |  |  | 4c. County of Death<br>Baltimore   |  |
| Funeral<br>Director  | 5. Social Security Number<br>212-05-1983  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>91 Yrs.  |  | If Under 1 Year<br>Months Days   |  | If Under 24 Hrs.<br>Hours Min.   |  |
|  | 8. Date of Birth (Month, Day, Year)<br>Nov. 6, 1905   |  | 9. Birthplace (State or Foreign Country)<br>Ireland  |  | 10a. State<br>Md.  |  | 10b. County<br>Baltimore   |  | 10c. City, Town or Location<br>Reisterstown  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>107 Neel Avenue  |  | 10f. Zip Code<br>21136   |  | 10g. Citizen of What Country?<br>U.S.A.  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
|  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Operator  |  |
| To Be Completed by Physician/Medical Examiner  | 16b. Kind of Business/Industry<br>Telephone Company   |  | 17. Father's Name (First, Middle, Last)<br>John Hanberry   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Bridget Keane   |  | 19a. Informant's Name/Relationship (Type, Print)<br>Sherry Brooks niece  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>125 Bayside Drive, Balto., Md. 21222  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Woodlawn Cemetery 03/05/97   |  | 20c. Location - City or Town, State<br>Woodlawn, Md.   |  | 21. Signature of Funeral Service Licensee<br><i>H. J. Ehlhardt</i>   |  | 22. Name and Address of Facility<br>Eckhardt Funeral Chapel 21117<br>11605 Reisterstown Rd., Owings Mills, Md.   |  |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Congestive Heart Failure<br>Due to (or as a consequence of):<br>b. Atherosclerotic Cardiovascular Disease<br>Due to (or as a consequence of):<br>c. Hypertension<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br>9 months   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                 |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br>Alzheimer's Dementia<br>GI Bleeding (chronic)   |  |  |  |  |  |  |  |  |  |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA   |  | 26. Place of Death (Check only one)<br>Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                         |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)   |  |
|  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| To the Hospital or Attorney: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: This certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><i>N. Deshpande MD</i>  |  | 29c. License number<br>D46082  |  | 29d. Date signed (Month, Day, Year)<br>3/3/97  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>NEETA DESHPANDE, M.D. 1 EASTERN BLVD. BALTIMORE, MD 21221                                      |  |
|  | 31. Date filed (Month, Day, Year)<br>MAR 03 1997  |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>   |  |  |  |  |  |  |  |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06081

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Jane Hossler

2. Date of Death

March 1, 1997

3. Time of Death

9 p.m.

4a. Facility Name (If not institution, give street and number)

Westminster Nursing &amp; Conv. Ctr.

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

216-22-8822

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 17, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1205 Random Ridge Rd.

10f. Zip Code

21157

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Homemaker

17. Father's Name (First, Middle, Last)

Edward Wilhelm

18. Mother's Name (First, Middle, Maiden Surname)

Addie Harris

19a. Informant's Name/Relationship (Type, Print)

Richard Hossler

Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4119 York Rd. #1, Millers, Md. 21102

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Leisters Church Cem. 03/04/97 Westminster, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Eckhardt Funeral Chapel  
3296 Charmil Dr., Manchester, Md. 21102

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lung Mass

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

032882

29d. Date signed (Month, Day, Year)

3/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert L. Moss 114 Business Center Dr. Rockville, Md

31. Date filed (Month, Day, Year)

MAR 03 1997

32. Registrar's Signature



21136

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

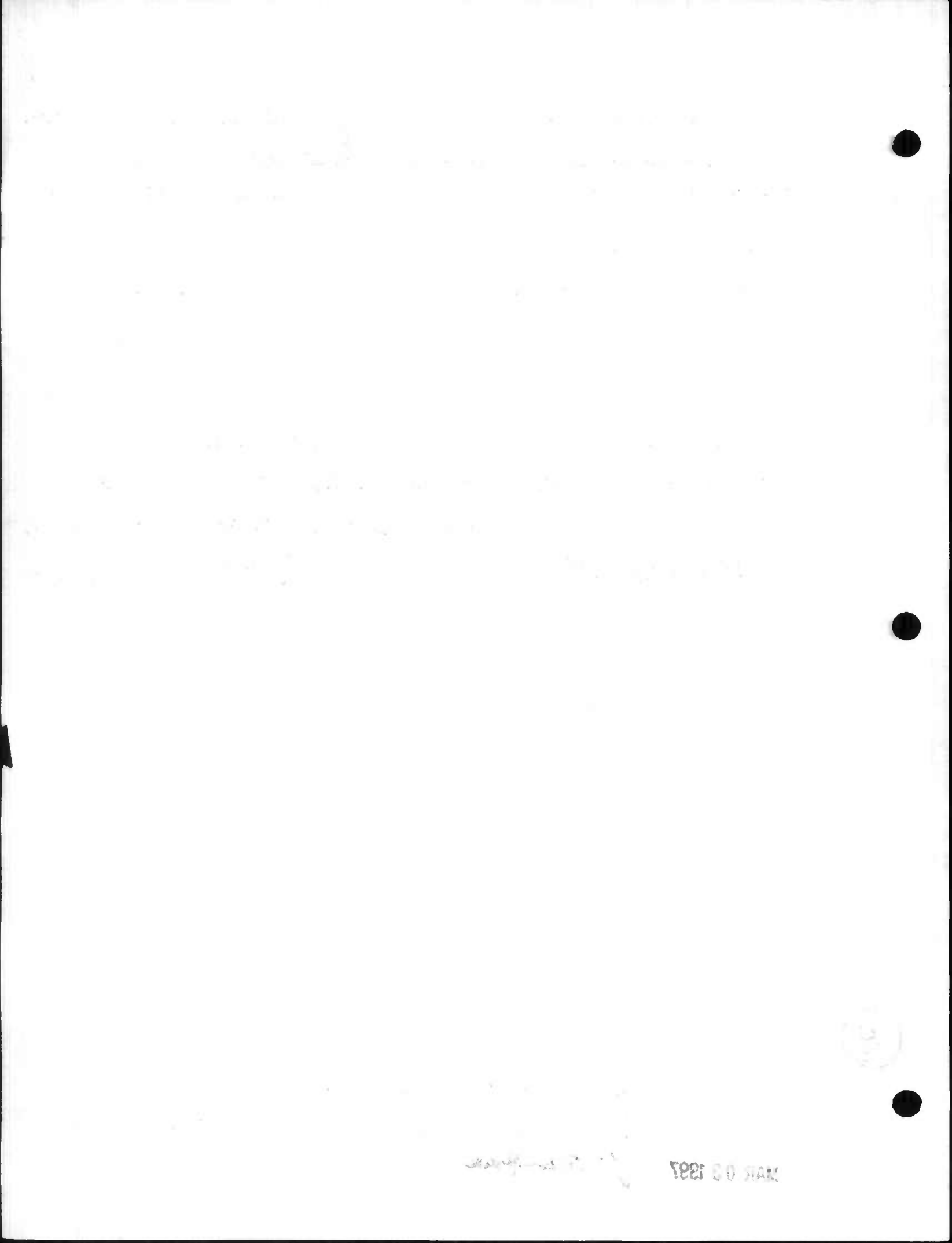
Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Registrar of Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial-transit permit.



1981 80 2121




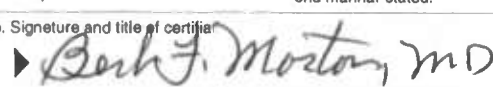
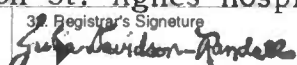
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06082

|  |   |   |  |   |  |  |  |  |
|--|---|---|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM ELWOOD HORSHAW</b>                   |   |  |   | 2. Date of Death<br>Month <b>February</b> Day <b>26</b> Year <b>1997</b> |  | 3. Time of Death<br><b>17:15 PM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>St. Agnes Hospital</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                 |  | 4c. County of Death<br><b>None</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-03-6152</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>12-31-19</b>   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>      |
|  | Usual Residence of Decedent   |   |  |   |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>None</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>601 Brookwood Rd.</b>   |   |   |  | 10f. Zip Code<br><b>21229</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Unknown</b> College (1-4 or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>  |  | 16b. Kind of Business/Industry<br><b>BG&amp;E</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Horshaw</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Hill</b>   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Margaret Horshaw/ Wife</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>601 Brookwood Rd. Baltimore, Maryland 21229</b>   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woodlawn</b>   |  | Date<br><b>3-12-97</b>  |  | 20c. Location - City or Town, State<br><b>Woodlawn, Maryland</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>The Derrick C. Jones Funeral Home<br/>4611 Park Heights Ave. Balto., Md. 21215</b>   |  |  |  |  |
| 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>e. <b>CORONARY ARTERY THROMBOSIS</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>24-48 HRS</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|  |   |   |  |   |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
|  |   |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how Injury occurred                                |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |  |  |  |
|  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |   |  |  |  |  |
| 29b. Signature and title of certifier<br><br><b>Bert F. Morton, MD</b>  |   |   |  | 29c. License number<br><b>D08949</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>February 27, 1997</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dr. Bert F. Morton St. Agnes Hospital 900 Caton Avenue Baltimore, MD 21229</b>  |   |   |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 03 1997</b>  |   |   |  | 32. Registrar's Signature<br>  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06083

Reg. No.

|  |  |   |  |   |  |  |  |   |
|--|--|---|--|---|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Edward F. Hodges</b>                        |   |  |   | 2. Date of Death<br>Month <b>March</b> Day <b>2</b> Year <b>1997</b> |  | 3. Time of Death<br><b>9:45 AM</b>   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>1125 Deanwood Rd.</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Parkville</b>             |  | 4c. County of Death<br><b>Baltimore</b>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>241 78 8507</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>47</b> Yrs.  | If Under 1 Year<br>Months Days                                       | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 18, 1949</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>   |
|  | Usual Residence of Decedent  |   |  |   |  |  |  |   |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Parkville</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><b>1125 Deanwood Rd.</b>   |  |   |  | 10f. Zip Code<br><b>21234</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Vietnam Era  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Automotive Technician</b>   |  | 16b. Kind of Business/Industry<br><b>Auto repair Garage</b>  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Frank Hodges</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anita Hobbins</b>   |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Bonnie M. Hodges / wife</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1125 Deanwood Rd., Baltimore, MD 21234</b>  |  |  |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Green Mount Crematory</b>  |  | Date<br><b>3/3/97</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |  |   |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>CAFA Stephen D. Lohrmann P.A.<br/>8717 Green Pastures Dr., Baltimore, MD 21286</b>   |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Lung Cancer</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>4 months</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|  |  |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |  |  |  |   |
| 29b. Signature and title of certifier<br><b>Peter White, Jr MD</b>   |  |   |  | 29c. License number<br><b>D36775</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/3/97</b>   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Peter White, Jr MD 720 Rutland Ave. Baltimore, MD 21205</b>   |  |   |  |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 03 1997</b>  |  | 32. Registrar's Signature<br>   |  |   |  |  |  |   |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06084

|   |   |   |  |   |  |                                 |   |   |   |  |   |
|---|---|---|--|---|--|---------------------------------|---|---|---|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ELIZABETH P. HURD</b>                                |   |  |   | 2. Date of Death<br>Month Day Year<br><b>MAR 01 1997</b> |                                 |   |   | 3. Time of Death<br><b>10 15 am</b>                         |  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>CHURCH HOME &amp; HOSPITAL</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b> |                                 |   |   | 4c. County of Death<br><b>BALTIMORE</b>                     |  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-34-3912</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs.         |                                 | 8. Date of Birth (Month, Day, Year)<br><b>3-17-1939</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |   |
|   | Usual Residence of Decedent   |   |  |   | 10a. State<br><b>Maryland</b>                            |                                 |   |   | 10b. County<br><b>N/A</b>                                   |  | 10c. City, Town or Location<br><b>Baltimore</b> |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 10e. Street and Number<br><b>316 S. Duncan Street</b>   |  |   |  | 10f. Zip Code<br><b>21231</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |                                 |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |   |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>0</b>  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>   |  |                                 |   | 16b. Kind of Business/Industry<br><b>Domestic</b>   |   |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>William Tarlton</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Katherine L. Rose</b>   |  |                                 |   |   |   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>William J. Hurd Jr. Husband</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>316 S. Duncan Street Baltimore, Md 21231</b>  |  |                                 |   |   |   |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>OakLawn Cemetery</b>   |  |                                 |   | 20c. Location - City or Town, State<br><b>3/4/97 Baltimore, Maryland</b>                    |   |  |   |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>David J. Weber Funeral Home</b><br><b>401 S. Chester Street Baltimore, Md 21231</b>  |  |                                 |   |   |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>VENTRICULAR FIBRILLATION</b><br>Due to (or as a consequence of):<br>b. <b>CARDIOMYOPATHY</b><br>Due to (or as a consequence of):<br>c. <b>HYPERTENSION</b><br>Due to (or as a consequence of):<br>d. <b>DIABETES MELLITUS</b> |   |   |  |   |  |                                 |   |   |   | Approximate Interval Between Onset and Death<br><b>2 DAYS</b><br><b>YEARS</b><br><b>YEARS</b><br><b>YEARS</b>  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |   |  |                                 |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |
|   |   |   |  |   |  |                                 |   |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
|   |   |   |  |   |  |                                 |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  | 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                 |   |   |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b> |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how Injury occurred  |   |
|   |   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                                 |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |  | 29b. Signature and title of certifier<br>  |  |                                 |   | 29c. License number<br><b>D42892</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>MAR 01 1997</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>FRANCIS S. CHUIDIAN 98 N BROADWAY SUITE 307 BALTIMORE MD 21231</b>   |   |   |  |   |  |                                 |   |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 03 1997</b>   |   |   |  | 32. Registrar's Signature<br>  |  |                                 |   |   |   |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a discussion of the results of the study. It presents the findings of the research and compares them with the results of previous studies.

4. The fourth part of the report is a conclusion and a list of references. The conclusion summarizes the main findings of the study and provides recommendations for future research. The references list the sources of information used in the study.

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06085

Reg. No.

|  |   |  |   |  |   |   |   |   |
|--|---|--|---|--|---|---|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JOHN JONES</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>FEB. 27, 1997</b>  |   | 3. Time of Death<br><b>1420 PM</b>  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>1923 EAST PRESTON STREET</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |   | 4c. County of Death<br><b>N/A</b>   |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-64-0411</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>40</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>FEB 4, 1957</b>                           |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|  | Usual Residence of Decedent   |  |   |  |   |   |   |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>N/A</b>  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |   |
|  | 10e. Street and Number<br><b>1923 E. Preston Street</b>   |  |   | 10f. Zip Code<br><b>21213</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>   |   |   |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                     |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 years</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Arranger</b>                      |  |   | 16b. Kind of Business/Industry<br><b>Pennock Wholesale Florist</b>                  |   |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>JOHN E. Williams, Sr.</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CARME HEIDELBERG</b>  |   |   |   |
| Physician<br>/Medical<br>Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>CARRIE H. GUINER / Mother</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4806 KATHLANO AVE BALTIMORE, Maryland 21207</b>   |   |   |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CARRISON Forest V.A. Cem.</b>  |  | Date<br><b>3/6/97</b>   |   | 20c. Location - City or Town, State<br><b>Owings Mills, Md</b>                              |   |
|  | 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>   |  |   |  | 22. Name and Address of Facility<br><b>CHAPMAN - Harris F.H. 5240 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>   |   |   |   |
|  | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Multiple Gunshot Wounds</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |   |   |   |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |   |   |   |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |   |
|  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |   |
|  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |   |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)<br><b>Found 2-27-97</b>   |  | 28b. Time of Injury<br><b>Found 1405 M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
|  | 28d. Describe how injury occurred<br><b>Subject was shot</b>  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>1923 E. Preston Baltimore City, Maryland</b>                   |  |   |   |   |   |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner as stated. |   |  |   | 29b. Signature and title of certifier<br><b>[Signature]</b>  |   | 29c. License number<br><b>O.C.M.E</b>   |   |   |
| 29d. Date signed (Month, Day, Year)<br><b>FEB. 28, 1997</b>  |   |  |   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Stephen S. Radentz, MO 111 Penn Street, Baltimore, Maryland 21201</b> |   |   |   |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 03 1997</b>  |   |  |   | 32. Registrar's Signature<br><b>[Signature]</b>  |   |   |   |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06086

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph R. JACHELSKI

2. Date of Death

Month Day Year  
February 25, 1997

3. Time of Death

5:50 P.M.

4e. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

217 01 7296

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Mar. 14, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7833 Eastdale Road

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Carpenter/Inspector

16b. Kind of Business/Industry

Baltimore City

17. Father's Name (First, Middle, Last)

Joseph Jachelski

18. Mother's Name (First, Middle, Maiden Surname)

Helen Zeilinski

19a. Informant's Name/Relationship (Type, Print)

Margaret Jachelski (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7833 Eastdale Road Baltimore, Maryland 21224

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Stanislaus Cem. 2/28/1997

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdziński Funeral Home PA  
1407 Old Eastern Ave Essex, Maryland 21221

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Acute renal failure

Due to (or as a consequence of):

b. Acute vasculitis

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Polyarteritis nodosa

Due to (or as a consequence of):

d.

Approximate interval between Onset and Death

7 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hepatic failure

Peritonitis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D15022

29d. Date signed (Month, Day, Year)

February 25, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. T. Paglinauan 9000 Franklin Square Dr. Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

MAR 03 1997

32. Registrar's Signature

John F. Anderson-Randall

State  
Registrar

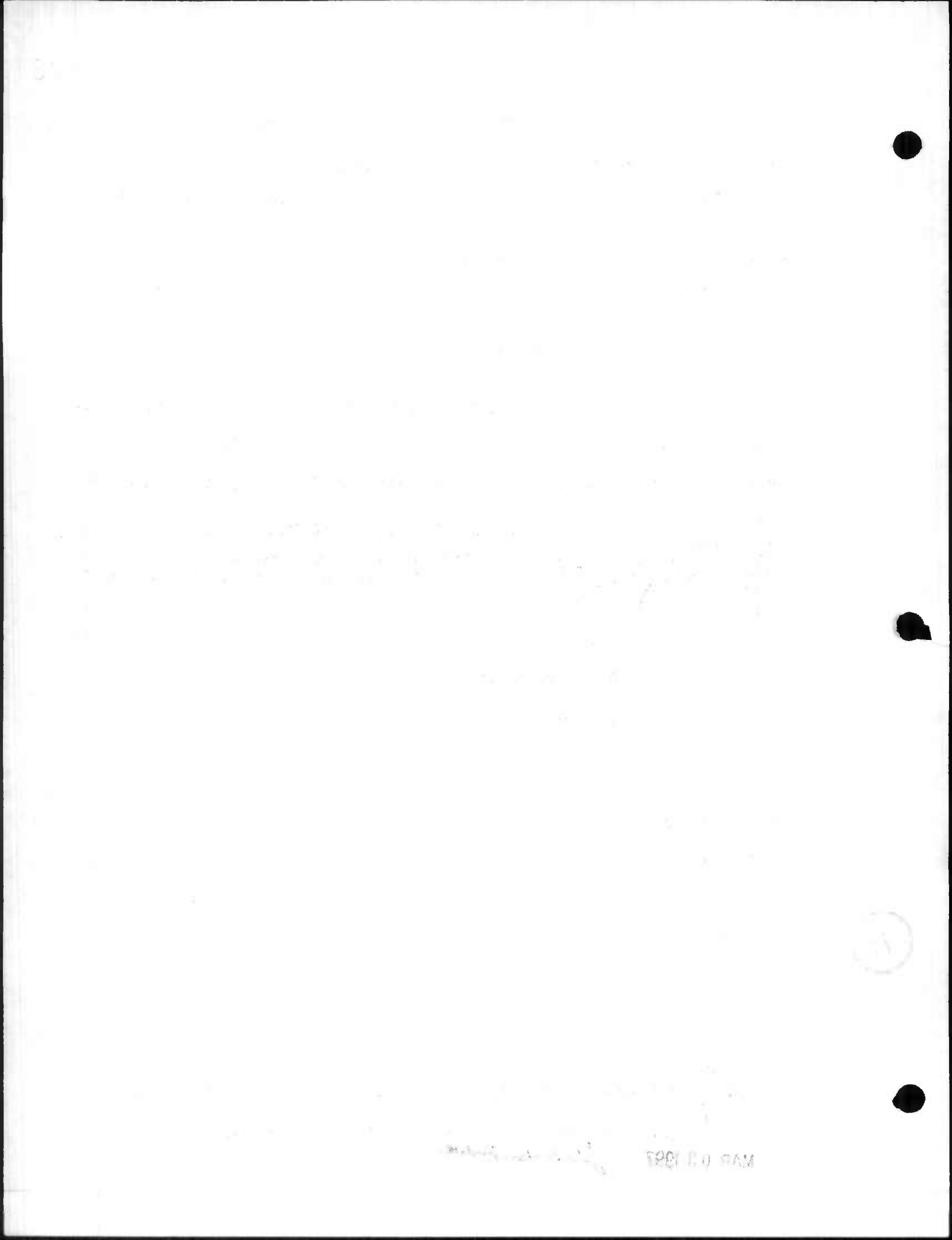
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



MAR 11 1993

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06087

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alphonso Knox

2. Date of Death

Month Day Year  
Feb 27 1997

3. Time of Death

6:50 AM

4a. Facility Name (If not institution, give street and number)

Lorien Frankford

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral  
Director

5. Social Security Number

218-62-8074

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 8, 1949

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

105 S. Amity Street

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7th grade

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Construction Worker

16b. Kind of Business/Industry

Private Business

17. Father's Name (First, Middle, Last)

NATHANIEL KNOX

18. Mother's Name (First, Middle, Maiden Surname)

Verna Gill

19a. Informant's Name/Relationship (Type, Print)

LINDA TURNER / Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

205 N. Amity Street #9 Baltimore, Md 21223

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Zion Cemetery

Date

3/3/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Darryl Harris

22. Name and Address of Facility

CHAYMAN - HARRIS F.H.  
5244 REISTERSTOWN RD  
BALTIMORE, MARYLAND 2121523a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Sepsis

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

48 hrs

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Aspiration Pneumonia

Due to (or as a consequence of):

2 weeks.

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

status epilepticus

CVA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Thomas J. Russi MD

29c. License number

D50785

29d. Date signed (Month, Day, Year)

Feb 27, 1997.

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Thomas J. Russi MD 10805 Hickory Ridge Rd Columbia MD.

31. Date filed (Month, Day, Year)

MAR 03 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

The Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To be completed by the Funeral Director: After this certificate has been signed by the attending physician and  
completing filed in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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Items 5,7 3-3-97 FilmG745 W.H.Per F/H

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06088

Reg. No.

|  |  |                                      |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
|--|--|--------------------------------------|---|--|--|--|--|---|--|---|---|----|--------------------------------------|--|--|--|--|--|--|--|---|----------------------------------|--|--|--|--|--|--|--|--|----|----------------------------------|--|--|--|--|--|--|--|----|----------------------------------|--|--|--|--|--|--|--|----|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>John Walter Kenney</b>  |                                      |   |  |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>1</b> Year <b>1997</b>         |   | 3. Time of Death<br><b>11:00 AM</b>  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>VA MHCS FORT HOWARD DIVISION</b>  |                                      |   |  |  |  | 4b. City, Town, or Location of Death<br><b>FORT HOWARD</b>                   |   | 4c. County of Death<br><b>BALTIMORE</b>  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-44-7793</b><br><b>213-28-8469</b>  |                                      | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>49</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>08-03-1947</b>                     |   | 9. Birthplace (State or Foreign Country)<br><b>N.C.</b>  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
|  | Usual Residence of Decedent  |                                      |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD.</b>   |                                      | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>DUNDALK</b>  |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
|  | 10e. Street and Number<br><b>2980 YORKWAY</b>  |                                      |   |  | 10f. Zip Code<br><b>21222</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                               |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |                                      | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> Collega (1-4or 5+) <b>10</b>  |                                      |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CARPENTER</b>  |  |  | 16b. Kind of Business/Industry<br><b>CONSTRUCTION</b>                   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>ALBERT WHITT</b>   |                                      |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>AGNES MEILHAMMER</b> |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>EDWARD WHITT/ BROTHER</b>   |                                      |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>110 SHIPWAY DUNDALK, MD. 21222</b>   |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CEM. GARRISON FOREST VET.</b>  |  | Date<br><b>3/5/97</b>  |  | 20c. Location - City or Town, State<br><b>OWINGS MILLS, MD.</b>              |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Phillip Starks</i>   |                                      |   |  | 22. Name and Address of Facility<br><b>BRADLEY-ASHTON FUNERAL HOME, INC.</b><br><b>2134 WILLOW SPRING RD. DUNDALK, MD. 21222</b>   |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |                                      |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
|  | <table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td colspan="8">Head and Neck Cancer With Metastasis</td> <td rowspan="4">Approximate Interval Between Onset and Death<br/><b>8 Months</b></td> </tr> <tr> <td colspan="9">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td colspan="8">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td colspan="8">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td colspan="8"></td> <td></td> </tr> </table> |                                      |   |  |  |  |  |   |  |   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Head and Neck Cancer With Metastasis |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>8 Months</b> | Due to (or as a consequence of): |  |  |  |  |  |  |  |  | b. | Due to (or as a consequence of): |  |  |  |  |  |  |  | c. | Due to (or as a consequence of): |  |  |  |  |  |  |  | d. |  |  |  |  |  |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a.   | Head and Neck Cancer With Metastasis |   |  |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>8 Months</b> |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
|  | Due to (or as a consequence of):   |                                      |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
|  | b.   | Due to (or as a consequence of):     |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
|  | c.   | Due to (or as a consequence of):     |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
| d.   |  |                                      |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cachexia</b>  |  |                                      |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |                                      |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                      |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                      |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                      |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |                                      |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |                                      |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
| 28a. Date of Injury (Month, Day, Year)   |  |                                      |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
| 28b. Time of Injury<br><b>M</b>  |  |                                      |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                      |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
| 28d. Describe how Injury occurred  |  |                                      |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |                                      |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |                                      |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                      |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>John Duggirala</i>   |  |                                      |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
| 29c. License number<br><b>D30528</b>   |  |                                      |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>3/1/97</b>   |  |                                      |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>Bala Duggirala, MD 9600 North Point Road Fort Howard, MD 21052</b>  |  |                                      |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 03 1997</b>  |  |                                      |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |
| 32. Registrar's Signature<br><i>John Duggirala</i>   |  |                                      |   |  |  |  |  |   |  |   |   |    |                                      |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

TPPI 10-200

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06089

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hansel Lowry

2. Date of Death

February 26 1997

3. Time of Death

5:22 PM

4a. Facility Name (If not Institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

226-82-7680

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

43

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
December 25 1953

9. Birthplace (State or Foreign Country)

Richmond VA.

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

912 Hingham Harbour

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 73-93

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4or 5+)  
4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Military

16b. Kind of Business/Industry

Air Force

17. Father's Name (First, Middle, Last)

Hannibal

Lowry

18. Mother's Name (First, Middle, Maiden Surname)

Emily

M.

Diamond

19a. Informant's Name/Relationship (Type, Print)

Heather Lowry - spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

912 Hingham Harbour Pasadena, Maryland 21122

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc.

Date

3/3/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Hilary L. Stallings Jr.

22. Name and Address of Facility

Stallings Funeral Home P.A.  
3111 Mountain Road Pasadena, Maryland 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Right Cerebral Infarction

Due to (or as a consequence of):

38hr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Right Middle Cerebral Artery Thrombosis

Due to (or as a consequence of):

40hr

c. Secondary Massive Cerebral Edema

Due to (or as a consequence of):

14hr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

Inpatient ☒2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. J. Anderson

29c. License number

D24290

29d. Date signed (Month, Day, Year)

2/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

64S Baltimore Annapolis Blvd. Suite #105 Severna Park, MD 21146

31. Date filed (Month, Day, Year)

MAR 03 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

41

1001 20 200



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06090

Items: 23 part I, 27 per ME0 G-745 3/4/97 reb **Certificate of Death**

Reg. No.

|  |  |  |   |                                |  |
|--|--|--|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ALPHENIA MARGARET LANE</b>  |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>22</b> Year <b>1997</b>  |                                | 3. Time of Death<br><b>12:07 PM</b>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>ST. AGNES HOSPITAL</b>  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |                                | 4c. County of Death<br><b>N/A</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>175-38-0048</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                       | 7. Age (In yrs. last birthday)<br><b>49</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>08/08/1947</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>AL</b>   |                                |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent  |  |   |                                |  |
|  | 10a. State<br><b>MD.</b>   | 10b. County<br><b>Baltimore</b>  | 10c. City, Town or Location<br><b>Catonsville</b>   |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>P.O. Box 3235 Wade Ave.</b>   |  | 10f. Zip Code<br><b>21228</b>   |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |                                |  |
|  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerk</b>   |  | 16b. Kind of Business/Industry<br><b>Dept. of Public Assistance</b>   |                                |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>George G. Lane</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary E. MacDaniel</b>   |                                |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary E. Lane/ Mother</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1151 Spruce St. Chester, PA. 19013</b>  |                                |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Haven Memorial Park</b>  |                                | 20c. Location - City or Town, State<br><b>3/1/97 Chester, PA.</b>  |
|  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Sterling Ashton Funeral Home, Inc.<br/>736 Edmondson Ave. Balto., MD. 21228</b>  |                                |  |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of): |  |   |                                |  |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                |  |
|  | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |                                |  |
|  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |                                |  |
|  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br><b>M</b>  |
|  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |                                |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |
|  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |                                |  |
|  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>O.C.M.E.</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 23, 1997</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ann Dixon M.D. 111 Penn Street, Baltimore, Maryland 21201</b> |  |  |   |                                |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 03 1997</b>  |  | 32. Registrar's Signature<br> |   |                                |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director; page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 24a per PHY Film G754 3-3-97 rja

## Certificate of Death

Reg. No.

97 06091

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Lunsford

2. Date of Death

Month

Day

Year

2

23

97

3. Time of Death

4:45AM

4a. Facility Name (If not institution, give street and number)

Dinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

220-38-6947

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Feb. 3, 1942

9. Birthplace (State or Foreign Country)

md

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5119 yellow wood Ave.

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

3yr.

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

state official

16b. Kind of Business/Industry

Human Resources

17. Father's Name (First, Middle, Last)

William G. Lunsford Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Lynette Dolos

19a. Informant's Name/Relationship (Type, Print)

myra F. Lunsford - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5119 yellow wood Ave. Balto. md 21209

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory

Date

2/27/97

20c. Location - City or Town, State

Balto. md.

21. Signature of Funeral Service Licensee

Glynn S. Starnes

22. Name and Address of Facility

March 1st - H. West

4300 Wabash Avenue Balto. md

21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Approximate Interval Between Onset and Death

Minutes

Due to (or as a consequence of):

b. Left ventricular hypertrophy

&gt;10 yrs

Due to (or as a consequence of):

c. Hypertensive Cardiovascular disease

&gt;15 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic renal failure on hemodialysis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John H. Sadler MD

29c. License number

DR336

29d. Date signed (Month, Day, Year)

2/25/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John H. Sadler, M.D. 733 W. 40th St. Balto, MD 21211

31. Date filed (Month, Day, Year)

MAR 03 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06092

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Wendell Leak

2. Date of Death

Feb. 28 1997 8:15 A

3. Time of Death

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

Joseph Richie House

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NONE

5. Social Security Number

212-46-0274

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Feb. 27 1947

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

NONE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

620 Kohn Drive

10f. Zip Code

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chef

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Andrew Leak

18. Mother's Name (First, Middle, Maiden Surname)

Grace Henry

19a. Informant's Name/Relationship (Type, Print)

Alkneuse Hardaway

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

620 Kohn Dr. Baltimore, Md. 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARbutus Memorial Pk. 3/5/97 Baltimore, MD.

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

The DERRICK C. JONES FUNERAL HOME  
4211 PARK HEIGHT AVE. BALTO, MD. 21215

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Respiratory Arrest

Approximate Interval Between Onset and Death

minutes

Due to (or as a consequence of):

Congestive Heart Failure

1 mo.

Due to (or as a consequence of):

Cerebral Thrombosis

4 mos.

Due to (or as a consequence of):

Endocarditis

8 yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Intravenous Drug Abuse.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

008400

29d. Date signed (Month, Day, Year)

2-28-97

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Robert C. Truwin MD 838 N. E. 1st St. Balto Md 21201

31. Date filed (Month, Day, Year)

MAR 03 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

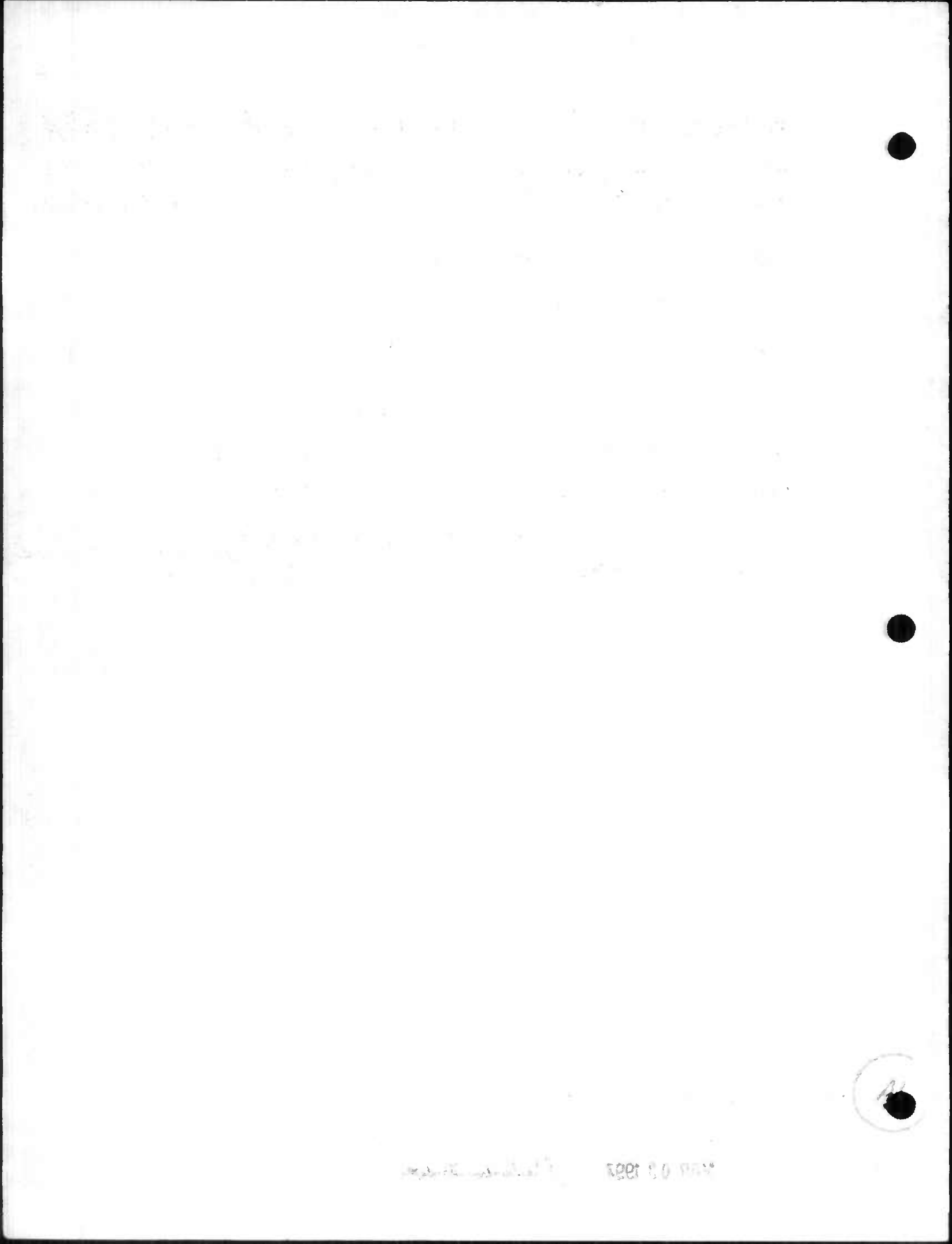
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06093

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elmer Martin

2. Date of Death  
Month Day Year

2 26 97

3. Time of Death

3:45 pm

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical Systems

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

217-50-6856

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

May 23, 1948

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

Maryland

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2305 W. Lafayette Ave

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: VET-NAN

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 YEARS

LABORER

16. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

W. R. BRACE &amp; Co.

17. Father's Name (First, Middle, Last)

JOHN Z. Martin, SR.

18. Mother's Name (First, Middle, Maiden Surname)

Georgianna Kennedy

19a. Informant's Name/Relationship (Type, Print)

JOHN Z. Martin / Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2305 W. Lafayette Ave Baltimore, Md

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Barrison Forest U.S. Cem

Date:

3/6/97

20c. Location - City or Town, State

Owings Mills, Md

21. Signature of Funeral Service Licensee

Spring House

22. Name and Address of Facility

CHARTMAN - HARRIS F.H.

5040 REISTERSTOWN ROAD

BALTIMORE, MARYLAND 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. intracerebral hemorrhage

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

24 hours

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. H. G. S. M.

29c. License number

P10036

29d. Date signed (Month, Day, Year)

2/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barbara Lazio MD 225 Greene St Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 03 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Handwritten signature or initials.

Q. 6181

1981 10 11



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 06094

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |   |  |
|--|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner      | 1. Decedent's Name (First, Middle, Last)<br><b>Edward Leslie MCDONALD</b>   |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>28</b> , Year <b>1997</b>   |  | 3. Time of Death<br><b>2:10 AM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Rosedale</b>  |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director                    | 5. Social Security Number<br><b>214-26-6639</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>April 22, 1930</b>                                |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Baltimore, Md.</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore Co.</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| To Be Completed by Funeral Director    | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>9528 Holiday Manor Road</b>  |  | 10f. Zip Code<br><b>21236</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>                                       |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Steel Worker</b>  |  | 18b. Kind of Business/Industry<br><b>Bethlehem Steel</b>   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Glenwood L. McDonald</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gladys Jeanette Seay</b>  |  |  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Glenn G. McDonald (Son)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>23 Wesley Woods Court Kingsville, Md. 21087</b>   |  |  |  |   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp.</b>  |  | Date<br><b>3/01/97</b>   |  | 20c. Location - City or Town, State<br><b>Towson, Maryland</b>                              |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Jeffrey L. Gair</b>   |  | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.</b>   |  | Address<br><b>1050 York Road Towson, Md. 21204</b>   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | e. <b>Bronchopneumonia</b><br>Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death<br><b>1 Month</b>   |  |   |  |
|  | b. <b>Gastric Volvulus with Obstruction</b><br>Due to (or as a consequence of):   |  |   |  | <b>2 Months</b>  |  |   |  |
|  | c.<br>Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| d.<br>Due to (or as a consequence of): |   |  |   |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner      | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
|  |   |  |   |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |
|  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|  | 27. Manner of Death.<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                    |  | 29b. Signature and title of certifier<br><b>Marco Zamora MD</b>   |  | 29c. License number<br><b>D 40819</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>February 28, 1997</b>                             |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Marco Zamora MD. 9000 Franklin Square Dr. Balto, Md. 21237</b>   |  |   |  |  |  |   |  |
|  | 31. Date filed (Month, Day, Year)<br><b>MAR 03 1997</b>   |  | 32. Registrar's Signature<br><b>John Davidson</b>   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 also must be attached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. The first part of the report discusses the general situation of the country and the progress of the work during the year. It also mentions the results of the various projects and the financial position of the organization.

2. The second part of the report deals with the specific details of the work done in each of the different departments. It gives a more detailed account of the various projects and the results achieved in each one of them.

3. The third part of the report discusses the financial position of the organization and the results of the various projects. It also mentions the results of the various projects and the financial position of the organization.

4. The fourth part of the report discusses the financial position of the organization and the results of the various projects. It also mentions the results of the various projects and the financial position of the organization.

(H)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 06095

Physician  
/Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |                                |   |   |  |  |  |
|---|--|---|--|--|--------------------------------|---|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Margaret Micciche</b>  |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>28</b> , Year <b>1997</b>   |                                |   |   | 3. Time of Death<br><b>4 PM</b>  |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Good Samaritan Nursing Home</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |                                |   |   | 4c. County of Death<br><b>N/A</b>  |  |  |
| 5. Social Security Number<br><b>218-22-8347</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>Mar. 19, 1911</b>                                 |   | 9. Birthplace (State or Foreign Country)<br><b>Colorado</b>  |  |  |
| Usual Residence of Decedent   |  |   |  |  |                                |   |   |  |  |  |
| 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore City</b>   |                                |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
| 10e. Street and Number<br><b>2629 Hampden Ave.</b>  |  |   |  | 10f. Zip Code<br><b>21211</b>  |                                | 10g. Citizen of What Country?<br><b>United States</b>                                       |   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>3</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Registered Nurse</b>   |                                |   | 16b. Kind of Business/Industry<br><b>Health Care</b>                    |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>John Chillemi</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Concetta (Not Known)</b>   |                                |   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Laura J. Crawford (Granddaughter)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2629 Hampden Ave. Baltimore, Maryland 21211</b>  |                                |   |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holy Redeemer Cem.</b>   |  | Data<br><b>3/5/97</b>  |                                | 20c. Location - City or Town, State<br><b>Baltimore Maryland</b>                            |   |  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Milton J. Knight Jr</b>   |  |   |  | 22. Name and Address of Facility<br><b>Leonard J. Ruck, Inc.<br/>5305 Harford Rd. Baltimore, Maryland 21214</b>  |                                |   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Metastatic CARCINOMA of Colon</b><br>Dua to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Dua to (or as a consequence of):</b><br><b>c. Dua to (or as a consequence of):</b><br><b>d. Dua to (or as a consequence of):</b> |  |   |  |  |                                |   |   |  |  | Approximate Interval Between Onset and Death<br><b>2 years</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><b>Coronary Artery Disease</b>  |  |   |  |  |                                |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |                                |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |   |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicida <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  | 29c. License number<br><b>D19423</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>3/1/97</b>  |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>5601 Coch Raven Blvd Baltimore, Md 21239</b>   |  |   |  |  |                                |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 03 1997</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |                                |   |   |  |  |  |

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06096

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Medley

2. Date of Death

February 27 1997 07:27

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical System

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

216-40-8425

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

52

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
04-10-44

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1615 Montpelier Street

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
Black15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th GradeCollege (1-4or 5+)  
NA16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Head Mechanic

16b. Kind of Business/Industry

Bugle Laundry

17. Father's Name (First, Middle, Last)

John C. Medley

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Hamilton

19a. Informant's Name/Relationship (Type, Print)

Teresa Medley

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1615 Montpelier Street Baltimore, Md. 21218

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

King Mem. Pk. Cem 03-04-97

Date

20c. Location - City or Town, State

Randallstown, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Maryland

WM.C. March FH 1101 E. North Ave. 21202

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. Multisystem Organ Failure  
Due to (or as a consequence of):

4 weeks

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Hepatitis C Virus  
Due to (or as a consequence of):

1 year

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alejandro Rodriguez

University of Maryland Medical System

31. Date filed (Month, Day, Year)

MAR 03 1997

32. Registrar's Signature

Alejandro Rodriguez

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: This certificate has been signed by the attending physician and  
completely filled in by the funeral director. Page 2 should be detached for use as the burial-transit

Medical Certification: To be Completed by Physician/Medical Examiner

8

State  
Registrar

1. 1981-1982

2. 1982-1983

3. 1983-1984

4. 1984-1985

5. 1985-1986

6. 1986-1987

7. 1987-1988

8. 1988-1989

9. 1989-1990

10. 1990-1991

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Items 19a, 19b, 20c 3-3-97 Film G745 W.H. Per State of Maryland / Department of Health and Mental Hygiene

97 06097

F/H

## Certificate of Death

Reg. No.

|  |  |   |   |  |  |  |  |   |   |    |                                    |   |    |  |    |  |    |
|--|--|---|---|--|--|--|--|---|---|----|------------------------------------|---|----|--|----|--|----|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Sarah Ellen Monroe</b>  |   |   |  | 2. Date of Death<br>Month <b>02</b> Day <b>22</b> Year <b>97</b>   |  | 3. Time of Death<br><b>1:05am</b>  |   |   |    |                                    |   |    |  |    |  |    |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>1509 Edmondson Avenue 1st. Floor</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>NA</b>   |   |   |    |                                    |   |    |  |    |  |    |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-22-3792A</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.                                       | If Under 1 Year<br>Months <b>05</b> Days <b>12</b>   | If Under 24 Hrs.<br>Hours <b>17</b> Min.   | 8. Date of Birth (Month, Day, Year)<br><b>05-12-17</b>   | 9. Birthplace (State or Foreign Country)<br><b>N.C.</b> |   |    |                                    |   |    |  |    |  |    |
|  | Usual Residence of Decedent  |   |   |  |  |  |  |   |   |    |                                    |   |    |  |    |  |    |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>n/a</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |   |    |                                    |   |    |  |    |  |    |
|  | 10e. Street and Number<br><b>1509 EDMONDSON AVENUE</b>   |   |   |  | 10f. Zip Code<br><b>21223</b>  |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |   |   |    |                                    |   |    |  |    |  |    |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                        |   |   |    |                                    |   |    |  |    |  |    |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8 th</b> College (1-4 or 5+) <b>-</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>DOMESTIC</b>                      |  | 16b. Kind of Business/Industry<br><b>OUTSIDE of HOME</b>   |  |  |   |   |    |                                    |   |    |  |    |  |    |
|  | 17. Father's Name (First, Middle, Last)<br><b>WILLIAM M. MONROE</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ROXANA MELVIN</b>  |  |  |   |   |    |                                    |   |    |  |    |  |    |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lorraine DENISE SCARBOROUGH</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1401 BLAIR MILL ROAD, Silver Spring #302, BALTO CO, MD 20904</b>                         |  |  |   |   |    |                                    |   |    |  |    |  |    |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD. NATIONAL CEM.</b>  |  | Date<br><b>2-28</b>  |  | 20c. Location - City or Town, State<br><b>SILVER SPRING, LAUREL CO, MD</b>                     |   |   |    |                                    |   |    |  |    |  |    |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   |   |  | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202</b><br><b>WM.C. March FH 1101 E. North Avenue</b>   |  |  |   |   |    |                                    |   |    |  |    |  |    |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |  |  |  |   |   |    |                                    |   |    |  |    |  |    |
|  | <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Acute Myocardial Infarction</b></td> <td rowspan="4">           Approximate Interval Between Onset and Death<br/><br/> <b>1 Hour</b><br/><br/> <b>2 years</b> </td> </tr> <tr> <td>b.</td> <td><b>Chronic Anemia Etiology unknown</b></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |   |   |  |  |  |  |   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <b>Acute Myocardial Infarction</b> | Approximate Interval Between Onset and Death<br><br><b>1 Hour</b><br><br><b>2 years</b> | b. | <b>Chronic Anemia Etiology unknown</b> | c. |  | d. |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a.   | <b>Acute Myocardial Infarction</b>  | Approximate Interval Between Onset and Death<br><br><b>1 Hour</b><br><br><b>2 years</b>   |  |  |  |  |   |   |    |                                    |   |    |  |    |  |    |
|  | b.   | <b>Chronic Anemia Etiology unknown</b>  |   |  |  |  |  |   |   |    |                                    |   |    |  |    |  |    |
|  | c.   |   |   |  |  |  |  |   |   |    |                                    |   |    |  |    |  |    |
|  | d.   |   |   |  |  |  |  |   |   |    |                                    |   |    |  |    |  |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |   |    |                                    |   |    |  |    |  |    |
|  |  |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |    |                                    |   |    |  |    |  |    |
|  |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |    |                                    |   |    |  |    |  |    |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |   |   |    |                                    |   |    |  |    |  |    |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |   |    |                                    |   |    |  |    |  |    |
|  |  | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |    |                                    |   |    |  |    |  |    |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |  |  |   |   |    |                                    |   |    |  |    |  |    |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |  |   |   | 29c. License number<br><b>018711</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2/24/97</b>  |  |   |   |    |                                    |   |    |  |    |  |    |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>BERNARD D. GONZALES, JR MM. 831 Poplar Grove St, Baltimore, MD 21223</b>  |  |   |   |  |  |  |  |   |   |    |                                    |   |    |  |    |  |    |
| 31. Date filed (Month, Day, Year)<br><b>MAR 03 1997</b>  |  |   |   | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |  |   |   |    |                                    |   |    |  |    |  |    |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06098

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MUZZETTA

MC DOWELL

2. Date of Death

Month Day Year

FEB. 27 1997

3. Time of Death

12:45

4a. Facility Name (If not institution, give street and number)

ST. AGNES Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

214-20-5746

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Mar. 10, 1920

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

md

10b. County

Balto.

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1211 Baker Ave.

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Job Corp

17. Father's Name (First, Middle, Last)

Stephen George

18. Mother's Name (First, Middle, Maiden Surname)

Rosa Mae Brown

19a. Informant's Name/Relationship (Type, Print)

Stephen McDowell - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1211 Baker Ave. Balto. md. 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Woodlawn Cemetery

Date

3/4/97

20c. Location - City or Town, State

Baltimore, md

21. Signature of Funeral Service Licensee

Blynn B. Harris

22. Name and Address of Facility

March Funeral Home - West  
4300 Wabash Ave. Balto. md 2121523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. HEPATIC FAILURE

Approximate  
Interval Between  
Onset and Death

2 WEEKS

Due to (or as a consequence of):

b. BREAST CARCINOMA

7 YEARS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Blynn B. Harris MD.

29c. License number

P09884

29d. Date signed (Month, Day, Year)

FEB. 27th 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR FRANCIS BWARD, ST AGNES HOSPITAL, 900 CATON AVENUE, BALTIMORE, MD, 21229

31. Date filed (Month, Day, Year)

MAR 03 1997

Julia B. Harris

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State  
Registrar

*Handwritten signature*

1981 09 03



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06099

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LARRY OSBORNE

2. Date of Death

FEBRUARY 28, 1997 23:45 PM

3. Time of Death

N/A

4a. Facility Name (If not institution, give street and number)

JOHN HOPKINS BAYVIEW HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

213-84-5874

6. Sex

M 2 F

7. Age (In yrs. last birthday)

35

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug 8, 1961

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

226 Colgate Avenue

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 Yes 2 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales Clerk

16b. Kind of Business/Industry

Automotive

17. Father's Name (First, Middle, Last)

John Osborne

18. Mother's Name (First, Middle, Maiden Surname)

Velma George

19a. Informant's Name/Relationship (Type, Print)

John Osborne/Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

226 Colgate Avenue Baltimore, Md 21222

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakeview Memorial Park

Date

3/4/97

20c. Location - City or Town, State

Sykesville, Md

21. Signature of Funeral Service Licensee

Edward A. Greath

22. Name and Address of Facility

Bradley Ashton Funeral Home, Inc.

2134 Willow Spring Rd Baltimore, Md 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending investigation  
2 Accident 6 Could not be determined  
3 Suicide 4 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. LARON LOCKE MD

29c. License number

OCME

29d. Date signed (Month, Day, Year)

MARCH 01, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J. LARON LOCKE, MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAR 03 1997

32. Registrar's Signature

Julia Davidson-Rodriguez

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

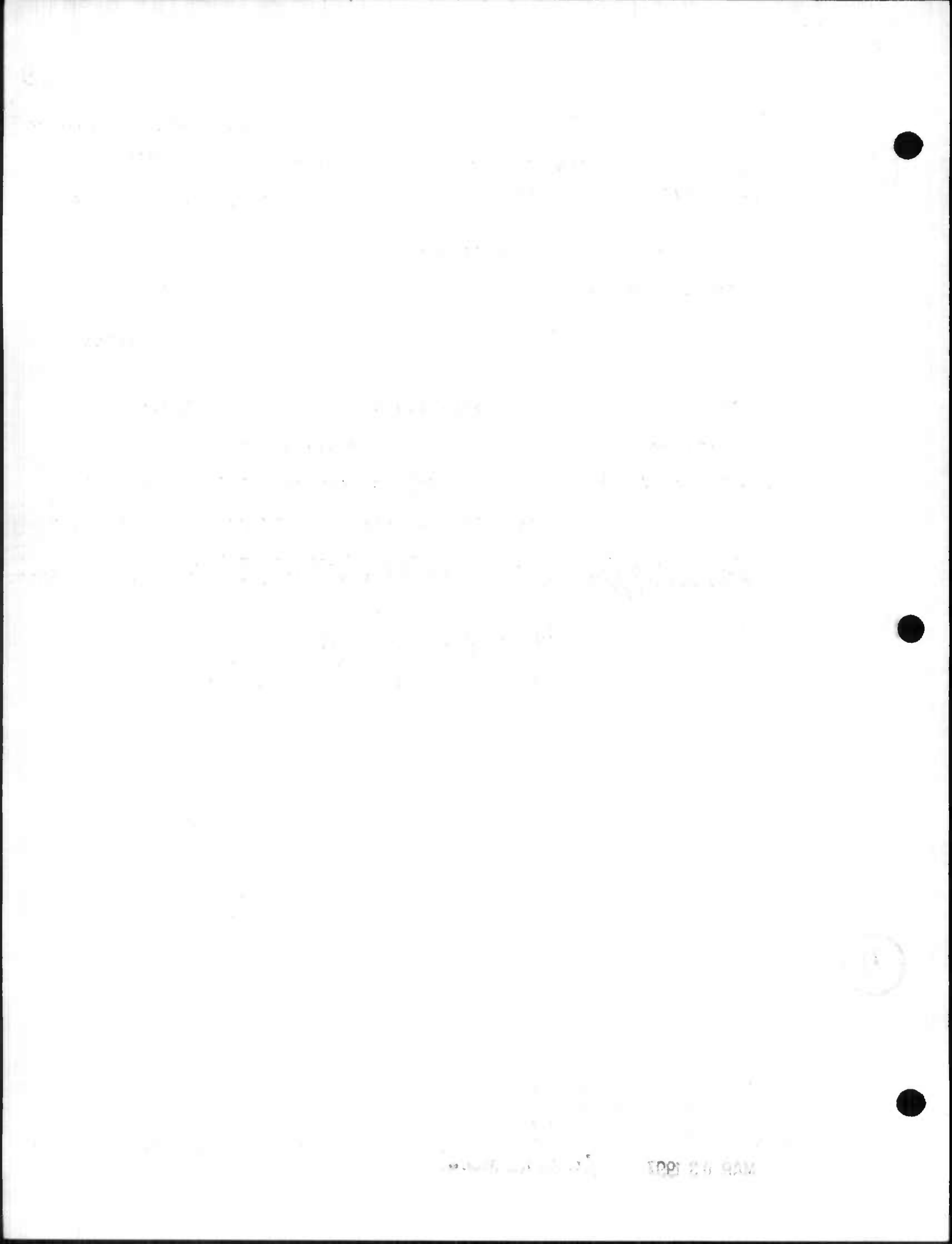
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Administrator: The law requires that the death certificate be executed within 24 hours after death. After the death certificate has been signed by the attending physician and To the Funeral Director: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



1001 26 9AM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06100

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Cornelia Opeth

2. Date of Death

Month Day Year  
February 28, 1997

3. Time of Death

5:40 AM

4a. Facility Name (If not institution, give street and number)

Riverview Nursing Center

4b. City, Town, or Location of Death

Essex

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

196-18-0790

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 27, 1916

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7413 Gunpowder Road

10f. Zip Code

21220

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Cashier

16b. Kind of Business/Industry

A&amp;P Company

17. Father's Name (First, Middle, Last)

William Matzky

18. Mother's Name (First, Middle, Maiden Surname)

Anna Ostroshina

19a. Informant's Name/Relationship (Type, Print)

Charles J. Wargo (Attorney)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2930 E. Baltimore St. Baltimore, Md. 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Belair Mem. Gardens 3/3/1997

Date

20c. Location - City or Town, State

Harford Co., Md.

21. Signature of Funeral Service Licensee

John Buczowski

22. Name and Address of Facility

Brudzinski Funeral Home P.A.  
1407 Old Eastern Avenue Essex, Md. 2122123a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Hypertensive Arteriosclerotic Coronary Vascular Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

4 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Old Coronary Arterial Disease

Congestive Heart Failure

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michael Schwartz

29c. License number

D19667

29d. Date signed (Month, Day, Year)

2-28-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Michael Schwartz 606 Hammonds Lane 21225

31. Date filed (Month, Day, Year)

MAR 03 1997

32. Registrar's Signature

Jill Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

11/11

12/12

13/13

14/14

15/15

16/16

17/17

18/18

19/19

20/20

21/21

22/22

23/23

24/24

25/25

26/26

27/27

28/28

29/29

30/30

31/31

32/32

33/33

34/34

35/35

36/36

37/37

38/38

39/39

40/40

41/41

42/42

43/43

44/44

45/45

46/46

47/47

48/48

49/49

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06101

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DENNY WAYNE PARSONS

2. Date of Death

Month

Day

Year

Feb 27 97

3. Time of Death

1058

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

AA

5. Social Security Number

220-36-4575

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

OCT. 6, 1941

9. Birthplace (State or Foreign Country)

Tenn.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Crownsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

915 Bargagni Rd.

10f. Zip Code

21032

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Arthur L.

Parsons

18. Mother's Name (First, Middle, Maiden Surname)

Vireda E.

Broyles

19a. Informant's Name/Relationship (Type, Print)

Carolyn I. Parsons

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

320 White Rocks Ct. Pasadena, Md. 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Cedar Hill Cemetery

Date

3/3/97

20c. Location - City or Town, State

Glen Burnie, Md.

21. Signature of Funeral Service licensee

[Signature]

22. Name and Address of Facility

Stallings Funeral Home PA

3111 Mountain Rd. Pasadena, Md. / 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Acute Myocardial Infarction

UNK

Due to (or as a consequence of):

b. Arteriosclerotic Heart Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending  
Investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

[Signature] Deputy

29c. License number

D06054

29d. Date signed (Month, Day, Year)

2/27/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William P. Jones, MD 695 America 21035

31. Date filed (Month, Day, Year)

MAR 03 1997

32. Registrar's Signature

[Signature]

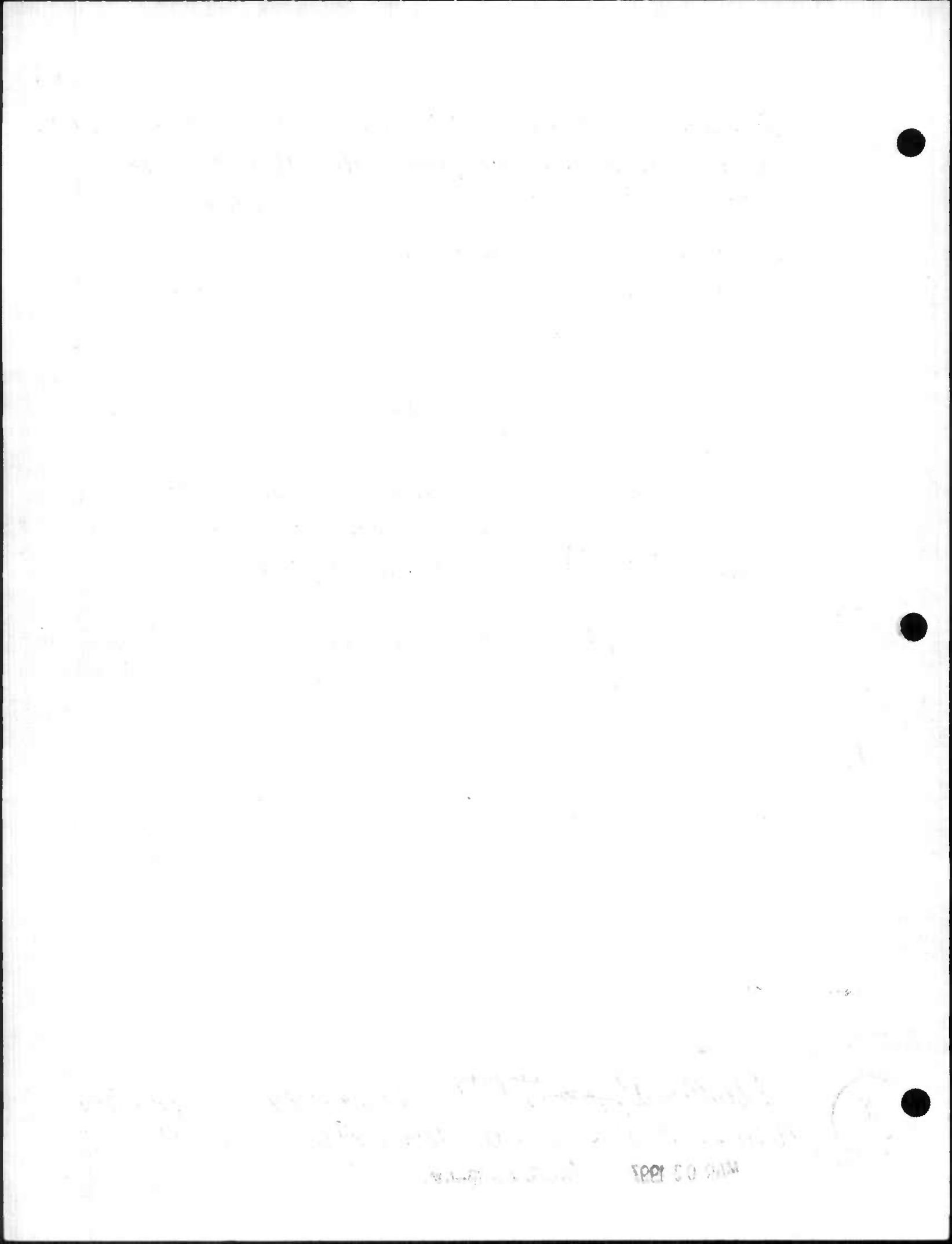
State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06102

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WALTER POWELL

2. Date of Death  
Month Day Year

2 24 97 11:35 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Bayview Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Na

Funeral  
Director

5. Social Security Number

217-16-1396

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

04-27-23

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md

10b. County

Na

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1903 Mosher Street

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
UnknownCollege (1-4 or 5+)  
Na

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

various trades

17. Father's Name (First, Middle, Last)

Walter Commer

18. Mother's Name (First, Middle, Maiden Surname)

Googie Powell

19a. Informant's Name/Relationship (Type, Print)

Cathy Malcomb

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21224-5505 Hopkins Bayview Circle Balto., Md. 2780

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Voshell Mem. Gardens 03-04-97 Dundalk, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

S. Valencia Holland

22. Name and Address of Facility Baltimore, Maryland 21202

WM.C. March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Colon CA

Due to (or as a consequence of):

Approximate interval Between Onset and Death

months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Insufficiency

Hepatic Insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. A. Beaman

29c. License number

D47479

29d. Date signed (Month, Day, Year)

2/25/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5505 Hopkins Bayview Circle Baltimore, MD 21224

31. Date filed (Month, Day, Year)

MAR 03 1997

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: This certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

9

1981-1982

1981-1982

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06103

|  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>DONALD FRANCIS PENNINGTON  |  |  |  | 2. Date of Death<br>Month FEBRUARY Day 26 Year 1997  |  | 3. Time of Death<br>10:05 PM   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>2100 BLOCK McCULLOH STREET   |  |  |  | 4b. City, Town, or Location of Death<br>BALTIMORE  |  | 4c. County of Death<br>NA  |  |
| Funeral<br>Director  | 5. Social Security Number<br>213-86-0803   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>21 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>10-16-75  |  |
|  | 10a. State<br>Md   |  | 10b. County<br>NA  |  | 10c. City, Town or Location<br>Baltimore   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                     |  |
| To Be Completed by Funeral Director  | 10e. Street and Number<br>419 Watty Court  |  |  |  | 10f. Zip Code<br>21201   |  | 10g. Citizen of What Country?<br>USA   |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10th Grade Collage (1-4or 5+) NA  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Laborer   |  | 16b. Kind of Business/Industry<br>Various trades   |  |
|  | 17. Father's Name (First, Middle, Last)<br>Donald Wilson   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Roshelle Pennington   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Francis Pennington   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>419 Watty Corut Baltimore, Md. 21201  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Voshell Mem. Pk. Cem. 03-04-97 Dundalk, Md.  |  | 20c. Location - City or Town, State  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Synette K. Jones</i>   |  |  |  | 22. Name and Address of Facility<br>Baltimore, Md. 21202<br>WM.C. March FH 1101 E. North Avenue  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><i>Gunshot of chest</i><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |  |  |  |  |  |  |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  |  |  |  |  |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |  |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input checked="" type="checkbox"/> Other (Specify) STREET |  |  |  |  |  |
|  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br>2/26/97  |  | 28b. Time of injury<br>2:52 M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |  |  | 28d. Describe how injury occurred<br><i>Subject shot</i>   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br><i>street</i>  |  | 28f. Location (Street and Number or Rural Route, Number, City or Town, State)<br><i>2100 block McCulloh Street Baltimore, Maryland</i> |  |
|  | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner as stated.   |  |  |  |  |  |  |  |
| State Registrar  | 29b. Signature and title of certifier<br><i>Theodore M. King, M.D.</i>   |  |  |  | 29c. License number<br>O.C.M.E.  |  | 29d. Date signed (Month, Day, Year)<br>FEBRUARY 27, 1997   |  |
|  | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br>Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201  |  |  |  |  |  |  |  |
| 31. Data filed (Month, Day, Year)<br>MAR 03 1997   |  |  |  | 32. Registrar's Signature<br><i>Julia M. ...</i> |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

3



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State of Maryland / Department of Health and Mental Hygiene

97 06104

## Certificate of Death

Reg. No.

|   |  |   |  |  |  |  |   |  |   |   |  |
|---|--|---|--|--|--|--|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>James W. PAUL IV</b>                                      |   |  |  | 2. Date of Death<br>Month Day Year<br><b>February 28, 1997</b> |  |   |  | 3. Time of Death<br><b>7:55A.M.</b>                         |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital Center</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Rosedale</b>        |  |   |  | 4c. County of Death<br><b>Baltimore</b>                     |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>220 90 4939</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>32</b> Yrs.               |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 1, 1965</b>              |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |   |  |
|   | Usual Residence of Decedent  |   |  |  |  |  |   |  |   |   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>n/a</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |
| 10e. Street and Number<br><b>3105 Rosekemp Ave.</b>   |  |   |  | 10f. Zip Code<br><b>21214</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>                            |   |  |   |   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b></b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Delivery Man</b>   |  |  | 16b. Kind of Business/Industry<br><b>Shipping Company</b>               |  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>James Walter Paul III</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Jane Toth</b>   |  |  |   |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>James W. Paul, III, father</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>533 3rd Ave. W., Apt.503; Seattle, WA 98119</b>  |  |  |   |  |   |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Green Mount Crematory</b>  |  | Date<br><b>3/1/97</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>                      |   |  |   |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>CAFA Stephen D. Lohrmann P.A.<br/>8717 Green Pastures Dr., Baltimore, MD 21286</b>  |  |  |   |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Sepsis</b><br>Due to (or as a consequence of):<br><br>b. <b>Metastatic stomach cancer</b><br>Due to (or as a consequence of):<br><br>c. <b>Liver cancer</b><br>Due to (or as a consequence of):<br><br>d.<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>2 days</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |  |
|   |  |   |  |  |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |
|   |  |   |  |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |   |   |  |
|   |  | 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |   |  |   |   |  |
| 29e. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  |   |  |   |   |  |
| 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>R D 2125</b>   |  |  | 29d. Date signed (Month, Day, Year)<br><b>February 28, 1997</b>         |  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dr. Hamilton Small 9000 Franklin Square Dr. Baltimore, Maryland 21237</b>  |  |   |  |  |  |  |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 03 1997</b>   |  |   |  | 32. Registrar's Signature<br>   |  |  |   |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

97 06105

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gaetano J. Ruscito

2. Date of Death

February 27, 1997

3. Time of Death

2:55 PM

4a. Facility Name (If not institution, give street and number)

2012 Searles Road

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

188-20-9190

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

Feb. 21, 1930

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10e. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2012 Searles Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1946-53

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Steel Worker

16b. Kind of Business/Industry

Steel Industry

17. Father's Name (First, Middle, Last)

John Ruscito

18. Mother's Name (First, Middle, Maiden Surname)

Mary Servella

19a. Informant's Name/Relationship (Type, Print)

Mrs. Margaret I. Ruscito/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2012 Searles Road Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Oak Lawn Cemetery 3/1/1997

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HEPATOCELLULAR CARCINOMA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LIVER CIRRHOSIS DUE TO HEPATITIS B.

DIABETES MELLITUS, TYPE II

HYPERTENSION, ESSENTIAL

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. Ruscito

29c. License number

D15022

29d. Date signed (Month, Day, Year)

SEPT. 30, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

7811 WISE AVE., BALTIMORE, MD 21222

31. Date filed (Month, Day, Year)

MAR 03 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

9

NOV 03 1981



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State of Maryland / Department of Health and Mental Hygiene

97 06106

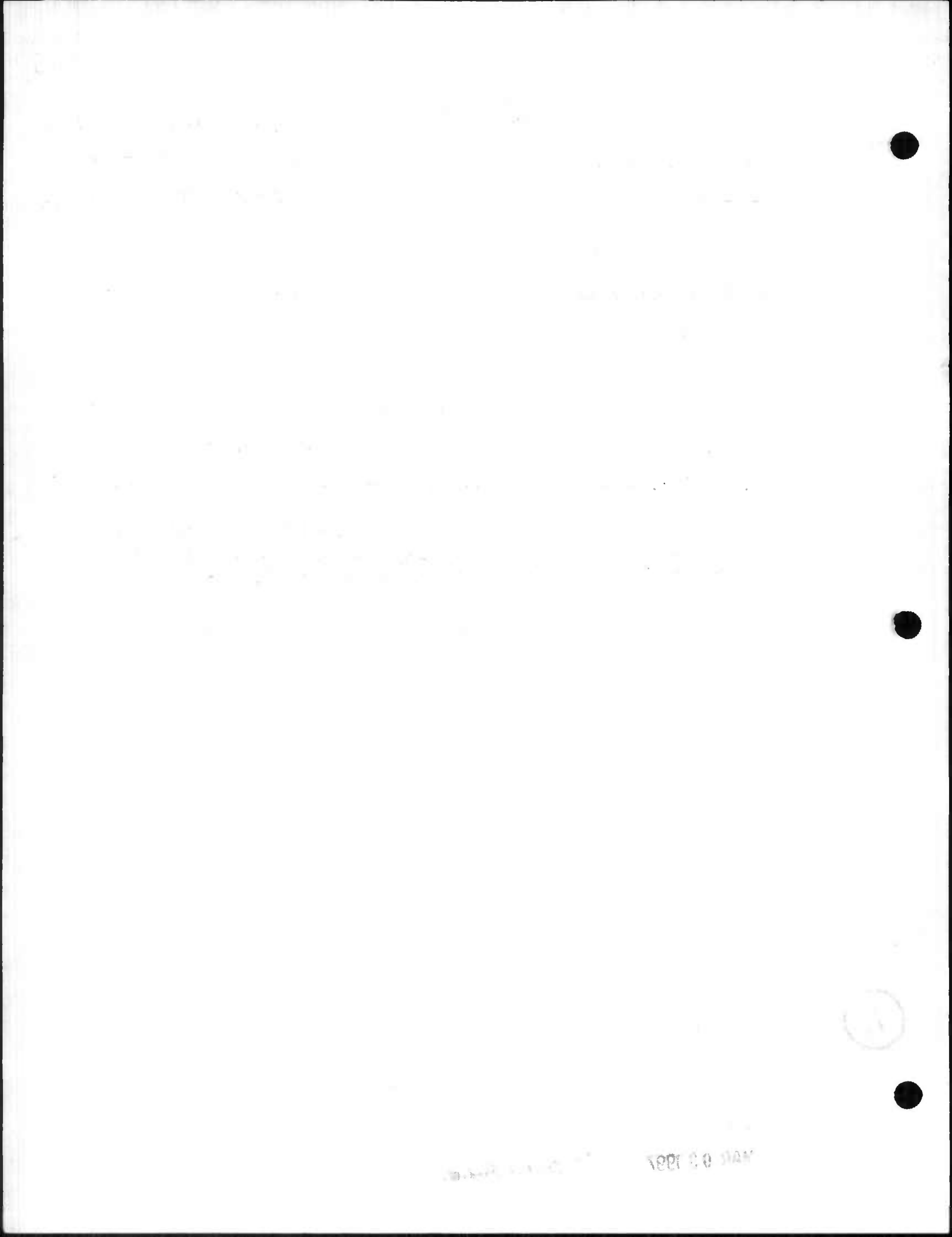
## Certificate of Death

Reg. No.

|   |   |  |   |  |   |  |   |  |
|---|---|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>John Edward Rzas</b>   |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>27</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>8:40 AM</b>                                      |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>2906 Cedarcrest Ave.</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Edgemere</b>   |  | 4c. County of Death<br><b>Baltimore</b>                                 |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-28-6284</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>64</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>April 2, 1932</b>             |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Edgemere</b>                          |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>2906 Cedarcrest Avenue</b>   |  | 10f. Zip Code<br><b>21219</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>                   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11 Years</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Blast Furnace</b>                 |  | 16b. Kind of Business/Industry<br><b>Steel Industry</b>   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>John M. Rzas</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Stella K. Miller</b>  |  |   |  |
|   | 19e. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Angela E. Rzas/Wife</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2906 Cedarcrest Avenue Edgemere, Maryland 21219</b>                                       |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gardens of Faith Cem. 3/1/1997</b>                                   |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>   |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave Dundalk, Maryland 21222</b>  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>METASTATIC BLADDER CARCINOMA</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |  |   |  |   |  |
|   | Approximate Interval Between Onset and Death<br><b>2 YEARS</b>  |  |   |  |   |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |  |   |  |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |   |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |   |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   |  |   |  |   |  |   |  |
| 28a. Date of Injury (Month, Day Year)<br><b>28b. Time of Injury</b><br><b>M</b><br><b>28c. Injury at Work?</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>28d. Describe how Injury occurred</b><br><b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b><br><b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b> |   |  |   |  |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |   |  |   |  |
| 29b. Signature and title of certifier<br>   |   |  |   |  |   |  |   |  |
| 29c. License number<br><b>D 21776</b>   |   |  |   |  |   |  |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 27 1997</b>  |   |  |   |  |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SURYA MUMTA MD 203 E PATAPSCO AV BALTIMORE 21225</b>   |   |  |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 03 1997</b>   |   |  |   |  |   |  |   |  |
| 32. Registrar's Signature<br>   |   |  |   |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 06107

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |   |   |                                |  |  |
|---|--|---|---|---|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br>WILLIAM O. RATLIFF  |  |   |   | 2. Date of Death<br>Month Day Year<br>FEBRUARY 25, 1997   |                                | 3. Time of Death<br>1:05AM   |  |
| 4a. Facility Name (If not institution, give street and number)<br>807 205th Street  |  |   |   | 4b. City, Town, or Location of Death<br>PASADENA  |                                | 4c. County of Death<br>ANNE ARUNDEL  |  |
| 5. Social Security Number<br>232-56-9371  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>59 Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth<br>Month Day Year<br>MARCH 27, 1937   |  |
| 9. Birthplace (State or Foreign Country)<br>WEST VIRGINIA   |  |   |   |   |                                |  |  |
| Usual Residence of Decedent   |  |   |   |   |                                |  |  |
| 10a. State<br>MARYLAND  |  | 10b. County<br>ANNE ARUNDEL   |   | 10c. City, Town or Location<br>PASADENA   |                                | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br>807 205th STREET  |  |   |   | 10f. Zip Code<br>21122  |                                | 10g. Citizen of What Country?<br>USA   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                                   |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 3rd College (1-4or 5+)  |  |   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>CARPENTER   |                                | 18b. Kind of Business/Industry<br>LAUREL RACE TRACK  |  |
| 17. Father's Name (First, Middle, Last)<br>HARVEY RUSSELL RATLIFF   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>VIRGINIA HICKS   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>MARY FRANCES RATLIFF - Spouse   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>807 205 th STREET PASADENA, MARYLAND 21122   |                                |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>GLEN HAVEN CEMETERY   |   | Data<br>FEB. 28, 1997   |                                | 20c. Location - City or Town, State<br>GLEN BURNIE, MARYLAND                                       |  |
| 21. Signature of Funeral Service Licensee<br>Hilary L. Stallings Jr.  |  |   |   | 22. Name and Address of Facility<br>STALLINGS FUNERAL HOME P.A.<br>3111 MOUNTAIN ROAD PASADENA, MARYLAND 21122  |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Renal cell Carcinoma advanced<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |  |   |   |   |                                |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |   |   |                                |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |   |                                |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |   |   |                                |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |                                |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of injury<br>M  |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  |
| 28d. Describe how injury occurred   |  |   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |   |                                |  |  |
| 29b. Signature and title of certifier<br>G. Nimmagadda  |  |   |   | 29c. License number<br>D39041   |                                | 29d. Date signed (Month, Day, Year)<br>February 26th '97   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>GAYATRI NIMMAGADDA 1600 Grain Highway Suite 410   |  |   |   |   |                                |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 03 1997  |  |   |   | 32. Registrar's Signature<br>John Davidson-Randall  |                                |  |  |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06108

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ethel Ruoss

2. Date of Death  
Month Day Year  
March 1, 19973. Time of Death  
4:20 p.m.

4e. Facility Name (If not institution, give street and number)

Cherrywood Manor Nursing &amp; Conv. Ctr.

4b. City, Town, or Location of Death

Reisterstown

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

182-30-1495

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

101 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 26, 1895

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10e. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Reisterstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

505 Sunbrook Road

10f. Zip Code

21136

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

4

College (1-4 or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Homemaker

17. Father's Name (First, Middle, Last)

John Davis

18. Mother's Name (First, Middle, Maiden Surname)

Betsey Parry

19e. Informant's Name/Relationship (Type, Print)

Joanne Will

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

505 Sunbrook Rd., Reisterstown, Md. 21136

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Evergreen Mem. Gardens 3/04/97

Date

20c. Location - City or Town, State

Finksburg, Md.

21. Signature of Funeral Service Licensee

H. J. Schmitt

22. Name and Address of Facility

Eckhardt Funeral Chapel

11605 Reisterstown Rd., Owings Mills, Md. 21117

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Atherosclerotic cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28e. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Julie H. H. H.

29c. License number

D27123

29d. Date signed (Month, Day, Year)

3/2/17

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Julia H. H. H. 750 Main St Reisterstown, MD 21136

31. Date filed (Month, Day, Year)

MAR 03 1997

32. Registrar's Signature

Julia H. H. H.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06109

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jack

ROCKWELL

2. Date of Death

February 26, 1997

3. Time of Death

3:15 P.M.

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

260-18-7536

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 2, 1909

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1829 Kitty Hawk Road

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Amusement Machines

17. Father's Name (First, Middle, Last)

Oswald J. Myers

18. Mother's Name (First, Middle, Maiden Surname)

Ursula L.

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

Betty J. Stockslager (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1729 Stockslager Rd. Oakland, Md. 21550

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount Crematory 2/28/1997

Date

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdinski Funeral Home P.A.  
1407 Old Eastern Avenue Essex, Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary artery disease

Due to (or as a consequence of):

b. Chronic obstructive pulmonary disease

Due to (or as a consequence of):

c. Alcohol abuse

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

12 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Arturo Norico 9000 Franklin Square Dr. Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAR 03 1997

State  
Registrar

Baltimore, Maryland 21215-0020

Pegs 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and to the Funeral Director. This certificate must be detached for use as the burial-transit completely filled in by the Funeral Director.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

9



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06110

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |
|---|--|--|---|--|---|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Marie Helen Simms  |  | 2. Date of Death<br>Month Day Year<br>February 28, 1997   |  | 3. Time of Death<br>11:08 AM  |
|   | 4a. Facility Name (If not institution, give street and number)<br>8324 Beryl Road  |  | 4b. City, Town, or Location of Death<br>Parkville   |  | 4c. County of Death<br>Baltimore  |
| Funeral<br>Director                           | 5. Social Security Number<br>215-05-5630   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday)<br>79 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>March 5, 1917 | 9. Birthplace (State or Foreign Country)<br>Maryland  |
|   | Usual Residence of Decedent<br>10a. State<br>Maryland  |  | 10b. County<br>Baltimore  | 10c. City, Town or Location<br>Parkville             |   |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>8324 Beryl Road   |  | 10f. Zip Code<br>21234  |
|   | 10g. Citizen of What Country?<br>United States   |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+)                                  |
|   | 16. Kind of Business/Industry<br>Own Home  |  | 17. Father's Name (First, Middle, Last)<br>Jacob Gabriel Mansperger   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Anna Speilman   |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Mr. Harry V. Simms, Jr. / Son  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>208 Sherwood Road Cockeysville, MD 21030   |  |   |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Parkwood Cemetery   |  | 20c. Date<br>3/3/97   |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>Brian A. Willem   |  | 22. Name and Address of Facility<br>Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, MD 21214   |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. RUPTURED THORACIC ABDOMINAL ANEURYSM<br>Due to (or as a consequence of):<br>b. HYPERTENSIVE ARTERIOSCLEROTIC<br>Due to (or as a consequence of):<br>c. HEART DISEASE<br>Due to (or as a consequence of):<br>d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death  |  |   |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |
|   | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |   |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br>Ruben S. Sebastian, MD   |  |   |
|   | 29c. License number<br>D-10397   |  | 29d. Date signed (Month, Day, Year)<br>3/1/97   |  |   |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>RUBEN S. SEBASTIAN, MD. BALTO, MD, 21234.  |  | 31. Data filed (Month, Day, Year)<br>MAR 03 1997  |  |   |
|   | 32. Registrar's Signature<br>Julia Davidson-Randall  |  | 33. State Registrar   |  |   |

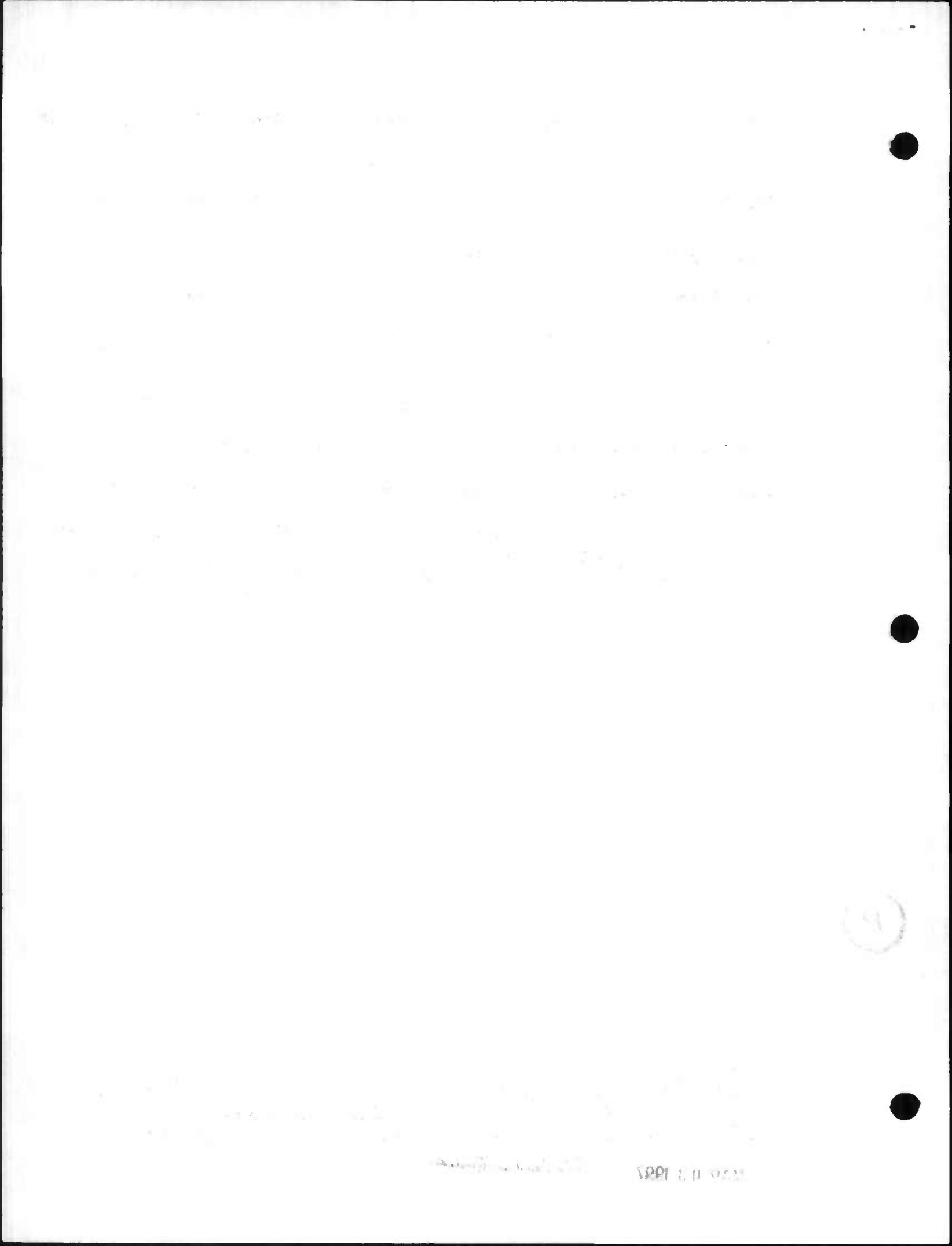
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06111

|  |  |  |   |  |   |  |  |  |
|--|--|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>ARCHIE STREET  |  |   |  | 2. Date of Death<br>Month Day Year<br>FEB. 26, 1997   |  | 3. Time of Death<br>11:56 am   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>903 N. MONTFORD  |  |   |  | 4b. City, Town, or Location of Death<br>BALTIMORE   |  | 4c. County of Death<br>n/a   |  |
| Funeral<br>Director  | 5. Social Security Number<br>423-36-0220   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>68 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>APR. 20, 1928                                 |  |
|  | 9. Birthplace (State or Foreign Country)<br>BURLINGHAM, L.   |  | 10a. State<br>MD  |  | 10b. County<br>n/a  |  | 10c. City, Town or Location<br>BALTIMORE   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  | 10e. Street and Number<br>903 N. MONTFORD AE.   |  |  |  |
|  | 10f. Zip Code<br>21205   |  |   |  | 10g. Citizen of What Country?<br>UNITED STATES  |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 th<br>College (1-4 or 5+) -  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>SHIPPING & RECEIVING                     |  | 16b. Kind of Business/Industry<br>BETHLEHEM STEEL   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>WALTER STREET   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>ARBELLA SPENCER  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>BEULAH STREET  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>903 N. MONTFORD ST., BALTIMORE, MD 21205   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>GARRISON FOREST VA CEM. 3+6 OWINGS MILLS, MD                                |  | 20c. Location - City or Town, State   |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>Bernard D Johnson   |  |   |  | 22. Name and Address of Facility<br>WM. C. MARCH FH.-1101 E. NORTH AVENUE   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>a. Non small cell Lung Carcinoma<br>Due to (or as a consequence of):<br>b. Mediastinal Metastases<br>Due to (or as a consequence of):<br>c. Possible liver + adrenal metastases<br>Due to (or as a consequence of):<br>d. h/o Tobacco Abuse |  |   |  |   |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |   |  |   |  |  |  |
| Physician<br>/Medical<br>Examiner  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how injury occurred   |  |  |  |
|  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                            |  |   |  |   |  |  |  |
| State Registrar  | 29b. Signature and title of certifier<br>Sharon D. Hush MD.  |  |   |  | 29c. License number<br>D47412   |  | 29d. Date signed (Month, Day, Year)<br>2/27/97                                       |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>SHARON D. HUSH MD 2323 Orleans St. Balto MD 21224  |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 03 1997   |  |  |   | 32. Registrar's Signature<br>John R. ... |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The death certificate is executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



RECEIVED

1991.10.10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06112

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bert

S

THOMAS

2. Date of Death

February 26, 1997

3. Time of Death

10:30 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

213-07-3433

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 1, 1907

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Chase

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12820 Eastern Avenue Extended

10f. Zip Code

21220

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrator

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Thomas Thomas

18. Mother's Name (First, Middle, Maiden Surname)

Florie Mason

19a. Informant's Name/Relationship (Type, Print)

David Thomas/Grandson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

67 B Suffolk Lane Sierra Madre, CA 91024

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery 2/28/1997

Data

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. Ischemic Heart Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

3 Days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End Stage Chronic Obstructive Pulmonary Disease

Pneumonia

Parkinson's Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D40819

29d. Date signed (Month, Day, Year)

February 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marco Zamora M.D. 2303 Kings Arms Drive Fallston, Maryland 21047

31. Date filed (Month, Day, Year)

MAR 03 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06113

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Melvin Turner

2. Date of Death

Month  
02Day  
28Year  
97

3. Time of Death

8:15am

4a. Facility Name (If not institution, give street and number)

513 Seagull Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

219-76-2500

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

55

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

12-19-41

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

513 Seagull Avenue

10f. Zip Code

21225

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Unknown

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Disabled

16b. Kind of Business/Industry

Never Worked

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Maxine

Turner

19a. Informant's Name/Relationship (Type, Print)

Maxine Russell

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

513 Seagull Avenue Baltimore, Maryland

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Mem. PK. Cem.

Date

03-04-97

20c. Location - City or Town, State

Md.

Randallstown

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C. March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

b. Cerebral Palsy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

sev. days  
55 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe kyphoscoliosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 22842

29d. Date signed (Month, Day, Year)

3/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sue W. Thompson MD, Gruhn Bldg, Suite 405, 5001 S. Harwood St., Balto, Md. 21225

31. Date filed (Month, Day, Year)

MAR 03 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

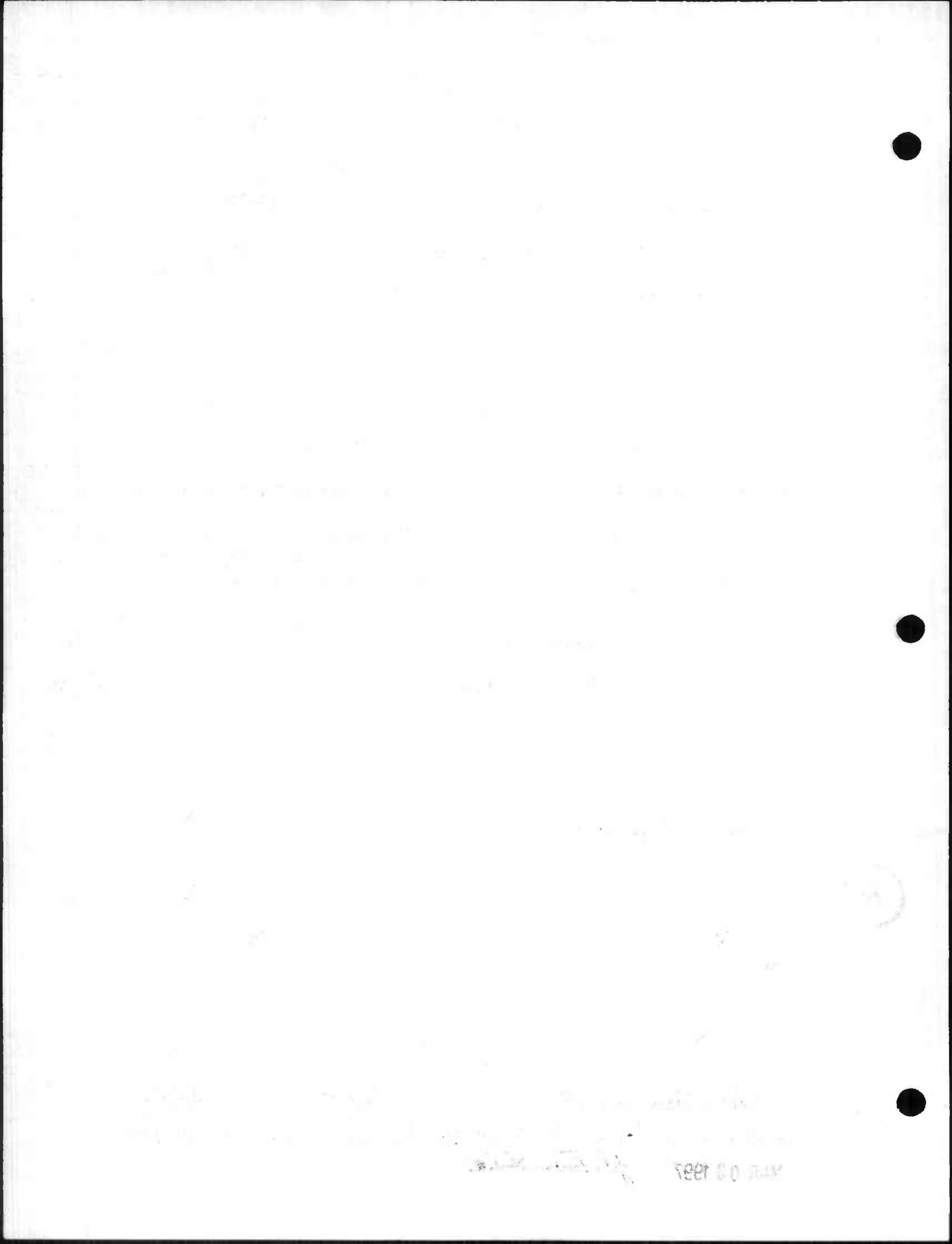
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This form requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06114

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

AGNES NORMA WELSH

2. Date of Death  
Month Day Year  
February 27, 19973. Time of Death  
2:07 AM

4a. Facility Name (If not Institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

217-03-8702

8. Sex  
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)  
77 Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)  
Nov. 19, 19199. Birthplace (State or Foreign  
Country)  
Md.

Usual Residence of Decedent

10a. State  
Md.10b. County  
Baltimore10c. City, Town or Location  
Towson10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number

2300 Dulaney Valley Rd.

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)  
416a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

John

Welsh

18. Mother's Name (First, Middle, Maiden Surname)

Bertha

Fritch

19a. Informant's Name/Relationship (Type, Print)

Mr. Melvin J. Welsh/brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1109 'D' Charles View Way Towson, Md. 21204

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gardens of Faith

Date

3/1/97

20c. Location - City or Town, State

Overlea, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. DEMENTIA

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and Title of Certifier

29c. License number

D2568C

29d. Date signed (Month, Day, Year)

2-28-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ebrahim Ipakchi, M.D. 7600 Osler Dr. Towson, Md. 21204

31. Date filed (Month, Day, Year)

MAR 03 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: This certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



SEP 10 1961

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06115

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Andrew Robert Wavrek, sr.

2. Date of Death

Feb 25 1997

3. Time of Death

1126

4a. Facility Name (If not institution, give street and number)

1416 Fairbanks Drive

4b. City, Town, or Location of Death

Hanover

4c. County of Death

AA

5. Social Security Number

143-16-3991

6. Sex

M 20 F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

08/11/1922

9. Birthplace (State or Foreign Country)

NJ

Usual Residence of Decedent

10a. State

NJ

10b. County

Middlesex

10c. City, Town or Location

Parlin

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

16-40 Skytop Gardens

10f. Zip Code

08859

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates

10/1942 9/1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Paralegal Specialist

16b. Kind of Business/Industry

Legal

17. Father's Name (First, Middle, Last)

Charles Wavrek

18. Mother's Name (First, Middle, Maiden Surname)

Mary Valush

19a. Informant's Name/Relationship (Type, Print)

Ms. Michaela E. Wavrek/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1416 Fairbanks Dr. Hanover, MD. 21076

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. Olivet Cemetery

Date

3/3/97

20c. Location - City or Town, State

Newark, NJ.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Sterling Ashton Funeral Home, Inc.

736 Edmondson Ave. Balto., MD. 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. Arteriosclerotic Heart Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Unk

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Deputy

29c. License number

D 06054

29d. Date signed (Month, Day, Year)

2-25-1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William P. Jones, M.D. 695 America Ct. 21035

31. Date filed (Month, Day, Year)

MAR 03 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

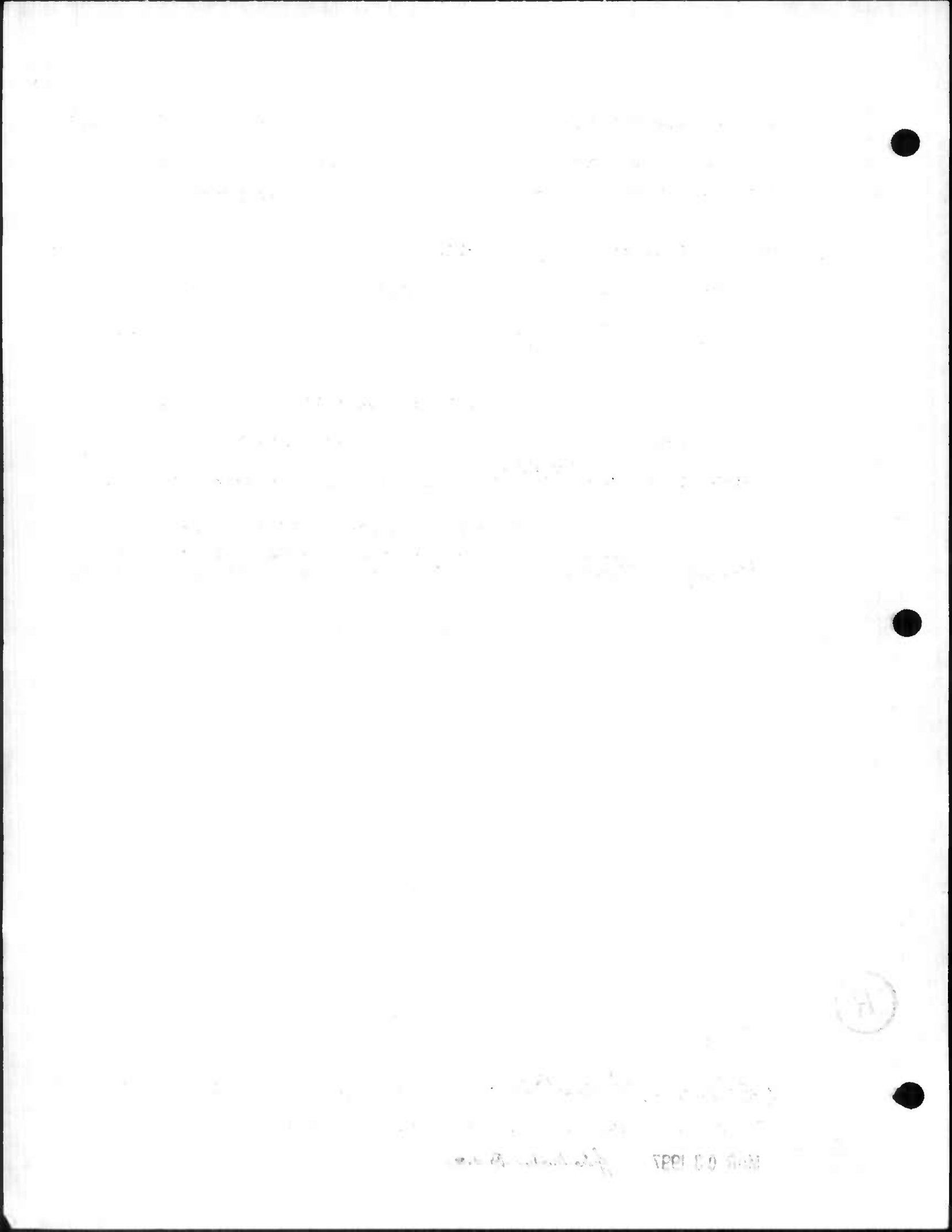
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours of death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06116

Items: 23 Part I, 27 per F.H. G-745 3/10/97 ~~Lab~~ Certificate of Death

Reg. No.

|   |  |  |   |   |  |  |   |   |  |
|---|--|--|---|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>DEBORAH WEBSTER</b>   |  |   |   | 2. Date of Death<br>Month Day Year<br><b>FEB. 22, 1997</b>   |  | 3. Time of Death<br><b>0746AM</b>                                       |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1202 WEST FAYETTE STREET</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>NONE</b>                                      |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-70-0828</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>46</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Mar. 05 1951</b>                                     |   | 9. Birthplace (State or Foreign Country)<br><b>Md.</b>  |  |
|   | Usual Residence of Decedent  |  |   |   |  |  |   |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Md.</b>   | 10b. County<br><b>None</b>   | 10c. City, Town or Location<br><b>Baltimore</b>   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |   |  |
|   | 10e. Street and Number<br><b>3437 Dupont Ave</b>   |  |   | 10f. Zip Code<br><b>21215</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |   |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>None</b>                          |   |  | 16b. Kind of Business/Industry<br><b>None</b>  |   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Randolph Webster</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jean Barnes</b>  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jean Webster / Mother</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3437 Dupont Ave. Baltimore, Md. 21215</b>  |  |   |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>3/1/97 Landsdown, Md.</b>  |  |   |   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br><b>Derrick C. Jones Funeral Home<br/>4611 Park Heights Ave. Balto. Md. 21215</b>   |  |   |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>Immediate Cause (Final disease or condition resulting in death)</b><br><b>a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b><br>Due to (or as a consequence of):<br><br><b>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</b><br><b>b.</b> Due to (or as a consequence of):<br><br><b>c.</b> Due to (or as a consequence of):<br><br><b>d.</b> |  |   |   |  |  |   | Approximate Interval Between Onset and Death  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide |  | 28a. Date of Injury (Month, Day Year)                                      |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |   | 28d. Describe how injury occurred   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                              |  | 29b. Signature and title of certifier<br>                                  |   | 29c. License number<br><b>O.C.M.E</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>FEB. 22, 1997</b>                                    |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Am Dixon 111 Penn Street, Baltimore, Maryland 21201</b>  |  |  |   |   |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 03 1997</b>   |  |  |   | 32. Registrar's Signature<br>   |  |  |   |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06117

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARIA FRANCES SCHNEBLY ANGLE

2. Date of Death

FEB.

Day

18

Year

1997

3. Time of Death

7:40 p.m.

4a. Facility Name (If not institution, give street and number)

Homewood Retirement Center

4b. City, Town, or Location of Death

Williamsport

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

220-46-6490

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

103

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Jan. 22, 1894

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Williamsport

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

16505 Virginia Ave.

10f. Zip Code

21795

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 yrs.

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Residence

17. Father's Name (First, Middle, Last)

Harry M. Schnebly

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Downs

19a. Informant's Name/Relationship (Type, Print)

Frances Vanden/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 Turn Berry Dr. Charles Town, WV. 25414

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Paul Cem. Feb. 21, 1997

Date

20c. Location - City or Town, State

Clear Spring MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Thompson Funeral Home, Inc.

P.O. Box 310 Clear Spring, MD 21722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Renal Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1-2 wks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Severe Dehydration

Due to (or as a consequence of):

1-2 wks

c. Inability to Eat And Drink

Due to (or as a consequence of):

3 wks

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Recent Acute Myocardial

Ischemia And Pulmonary Edema

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEPHEN E. METZGER, MD 747 NORTON AVE HAGGERSVILLE, MD

31. Date filed (Month, Day, Year)

FEB 20 1997

32. Registrar's Signature

John Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06118

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Madge Irene Albertie

2. Date of Death

February 6, 1997

3. Time of Death

8:30 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Fairland Nursing Home

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

725-09-1176

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug 31, 1905

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

511 Gorman Avenue

10f. Zip Code

20707

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

Grade 12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

McClain

19a. Informant's Name/Relationship (Type, Print)

Carol Aleksei

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1415 Virginia Ave. Severn, Maryland 21144

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory, Inc.

Date

2/7/97

20c. Location - City or Town, State

Catonsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donaldson Funeral Home, P.A.

313 Talbott Ave. Laurel, Maryland 20707-4389

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Acute myocardial infarction  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

6 hrs

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

DZ4942

29d. Date signed (Month, Day, Year)

Feb 7 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gregory A. Courton

317 Cherry Lane Laurel MD

31. Date filed (Month, Day, Year)

FEB 10 1997

32. Registrar's Signature

20707

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

8

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06119

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

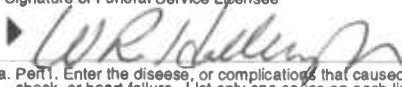

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |                                |   |  |
|--|--|---|--------------------------------|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Mary Lee Allen</b>  |  | 2. Date of Death<br>Month <b>February</b> Day <b>13</b> Year <b>1997</b>  |                                | 3. Time of Death<br><b>3:20 AM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Salisbury Center: Genesis Eldercare</b>   |  | 4b. City, Town, or Location of Death<br><b>Salisbury, MD</b>  |                                | 4c. County of Death<br><b>Wicomico</b>  |  |
| 5. Social Security Number<br><b>217-12-4230</b>  | 8. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.  | 6. Date of Birth<br>Month <b>05</b> Day <b>18</b> Year <b>14</b> |
| 9. Birthplace (State or Foreign Country)<br><b>Hornstown, VA</b>   |  |   |                                |   |  |
| Usual Residence of Decedent  |  |   |                                |   |  |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>Wicomico</b>   | 10c. City, Town or Location<br><b>Salisbury</b>   |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 10e. Street and Number<br><b>112 West London Avenue</b>  |  | 10f. Zip Code<br><b>21801</b>   |                                | 10g. Citizen of What Country?<br><b>USA</b>   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1</b> College (1-4or 5+)  |                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Factory Worker</b>  |  |
| 16b. Kind of Business/Industry<br><b>Manufacturing</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Edward Thomas Allen</b>   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eva Elizabeth Lillston</b>  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Kenneth Marriner-Nephew</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5833 Cumberland Dr., Salisbury, MD 21804</b>  |                                |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Wicomico Memorial Park</b>   |                                | 20c. Location - City or Town, State<br><b>Salisbury, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Holloway Funeral Home</b><br><b>501 Snow Hill Road, Salisbury, MD 21804</b>  |                                |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | a. <b>CONGESTIVE HEART FAILURE EXACERBATION</b><br>Due to (or as a consequence of):   |                                | Approximate Interval Between Onset and Death<br><b>1 Day</b>  |  |
| b. <b>CARDIO MYOPATHY</b><br>Due to (or as a consequence of):  |  | c.<br>Due to (or as a consequence of):  |                                | d.<br>Due to (or as a consequence of):  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>COPD w. RECENT EXACERBATION</b><br><b>MACNUTRITION</b><br><b>DEMENTIA</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown   |                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |                                | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 28f. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                |   |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D 39813</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>2/13/97</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Michael R. Atkins, M.D. 1104 Healthway Dr., Salisbury, MD 21804</b>   |  |   |                                |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 14 1997</b>  |  | 32. Registrar's Signature<br>  |                                |   |  |

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06120

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JERRY WAYNE ALLEN, SR.

2. Date of Death  
Month Day Year  
FEBRUARY 9 19973. Time of Death  
1945

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

219-42-8660

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Jan. 27, 1944

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

Wicomico

10c. City, Town or Location

Willards

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9176 Greenbranch Road

10f. Zip Code

21874

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Attendant

16b. Kind of Business/Industry

Poultry Grower

17. Father's Name (First, Middle, Last)

Raymond B. Allen

18. Mother's Name (First, Middle, Maiden Surname)

Martha Aycock Allen

19a. Informant's Name/Relationship (Type, Print)

Linda Allen, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9176 Greenbranch Rd. Willards, Md. 21874

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Eastern Shore Crematory

Data

2-10

20c. Location - City or Town, State

Lewes, De.

21. Signature of Funeral Service Licensee

William M. Short

22. Name and Address of Facility

Short Funeral Home

13 E. Grove St. Delmar, De. 19940

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Lung cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. cigarette smoking

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

James A. Cockroft, M.D.

29c. License number

D25674

29d. Date signed (Month, Day, Year)

2/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James A. Cockroft, M.D. 100 Power St Salisbury, Md 21804

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 11 1997

32. Registrar's Signature

Julia Brubaker-Rodell

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06121

## Certificate of Death

Reg. No.

|   |  |   |  |  |  |  |  |   |
|---|--|---|--|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>VERL K BUELL</b>                                    |   |  |  | 2. Date of Death<br>Month <b>02</b> Day <b>27</b> Year <b>97</b> |  | 3. Time of Death<br><b>1213</b>  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL CENTER</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>         |  | 4c. County of Death<br><b>WICOMICO</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-01-6359</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.   | If Under 1 Year<br>Months Days                                   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>07-08-05</b>   | 9. Birthplace (State or Foreign Country)<br><b>Dahlia, New York</b>   |
|   | Usual Residence of Decedent  |   |  |  |  |  |  |   |
| 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>Worcester</b>   |  | 10c. City, Town or Location<br><b>Berlin</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><b>1 Meadow Street</b>  |  |   |  | 10f. Zip Code<br><b>21811</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b>College</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>clerical</b>   |  | 16b. Kind of Business/Industry<br><b>Maryland Plating Co.</b>  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Wilbur J. Klein</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mina Benton Klein</b>  |  |  |  |   |
| 19e. Informant's Name/Relationship (Type, Print)<br><b>Dorothy T. Colbourne</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 16, Powellville, Md. 21852</b>  |  |  |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Salisbury Crematory</b>  |  | Data<br><b>2/18/97</b>   |  | 20c. Location - City or Town, State<br><b>Salisbury, Md.</b>   |  |   |
| 21. Signature of Funeral Service Licensee<br><b>Patricia L. Lennis</b>  |  |   |  | 22. Name and Address of Facility<br><b>Dennis Funeral Home<br/>P.O. Box 87, Snow Hill, Md. 21863</b>   |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. <b>RESPIRATORY ARREST</b><br>Due to (or as a consequence of):<br><br>b. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of): |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>CONGESTIVE HEART FAILURE, ATRIAL FIBRILLATION,<br/>FRACTURED LEFT HIP</b>  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |
|   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)<br><b>01-26-97</b>   |  | 28b. Time of Injury<br><b>2230</b> M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how Injury occurred<br><b>FELL WHILE TRANSFERRING TO BED</b>  |
|   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>GULL CREEK-1 MEADOW STREET</b>   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>BERLIN MD</b>   |  |   |
| 29e. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><b>John T. Bulkeley, M.D.</b>  |  |  |  |  |  |   |
|   |  | 29c. License number<br><b>D03599</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>02-17-97</b>   |  |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY MD 21801</b>  |  |   |  |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 17 1997</b>   |  | 32. Registrar's Signature<br><b>John T. Bulkeley</b>  |  |  |  |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





97 06122

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Martha Ellen Brown  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 15 1997  |  |  |  | 3. TIME OF DEATH<br>9:45 P M  |  |
| 4. SOCIAL SECURITY NUMBER<br>219-20-2087  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>75 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Aug. 19, 1921   |  |   |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Reeder's Memorial Home  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Boonsboro  |  |  |  | 9c. COUNTY OF DEATH<br>Washington   |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |  |  |   |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Washington   |  | 10c. CITY, TOWN OR LOCATION<br>Hagerstown   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br>414 East Franklin Street  |  |   |  | 10f. ZIP CODE<br>21740  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: white  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 0-12 College (1-4 or 5+) 1-   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>secretary  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>hospital  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Samuel R. Nunamaker  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Helen Mae Rohrer   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Linda Wolfe  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>414 East Franklin Street, Hagerstown, Maryland 21740   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt View Cemetery   |  | OATE<br>2-19-97  |  | 20c. LOCATION — City or Town, State<br>Sharpsburg, Maryland   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Scott M. Minnich</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Minnich Funeral Home<br>415 East Wilson Blvd., Hagerstown, Maryland 21740   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute myocardial infarction</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Coronary artery disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |  |  | Approximate interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Chronic obstructive lung disease.</i><br><i>Alzheimer's dementia</i>   |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |   |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |  |  | 29c. LICENSE NUMBER<br>D44996   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br>Feb 16, 1997   |  |   |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Zafar Malik, 20311 Lappans Road, Boonsboro, Maryland 21713 (301) 432-8470                                |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 20 1997  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06123

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John R. Braxton

2. Date of Death

February 13, 1997

3. Time of Death

9:15PM

4a. Facility Name (If not institution, give street and number)

VA Maryland Health Care System

4b. City, Town, or Location of Death

Perry Point

4c. County of Death

cecil

Funeral  
Director

5. Social Security Number

176-18-8648

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 16, 1918

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Rising Sun

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1728 Biggs Highway

10f. Zip Code

21911

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: 1941-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Twelve Years

College (1-4 or 5+)

-----

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chief Mate

16b. Kind of Business/Industry

U.S. Merchant Marine

17. Father's Name (First, Middle, Last)

Edward O. Braxton

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Smith

19a. Informant's Name/Relationship (Type, Print)

William O. Braxton (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1100 Lafayette Road, Wayne, Pennsylvania 19087

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Valley Forge Gardens

Date

2/18/97

20c. Location - City or Town, State

King of Prussia, Pennsylvania

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lee A. Patterson & Son Funeral Home  
Perryville, Maryland 21903-0188

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Liver cancer

Due to (or as a consequence of):

unknown

b. Alcohol Liver disease

Due to (or as a consequence of):

unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Cardio-respiratory Failure

Due to (or as a consequence of):

unknown

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? ☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

C1-0004144

29d. Date signed (Month, Day, Year)

2/14/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yasmin Behmanshah, M.D.

Perry Point, MD 21902

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

State  
Registrar

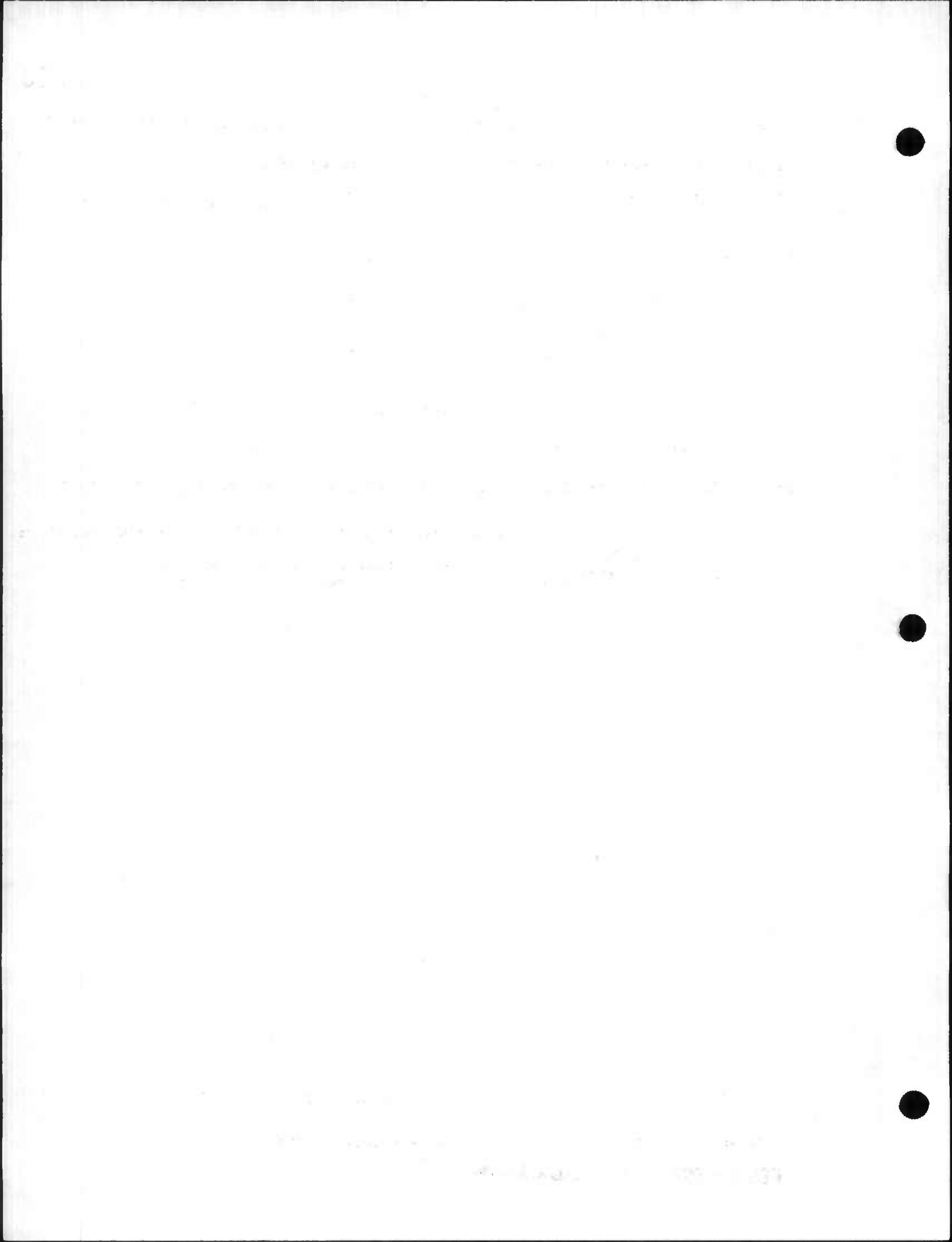
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06124

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SYLVESTER ELMER BOLDEN

2. Date of Death

FEB 17 1997

3. Time of Death

5:18 AM

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

Funeral  
Director

5. Social Security Number

213-22-7689

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

06/06/30

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Caroline

10c. City, Town or Location

Federalsburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

317 Brooklyn Avenue

10f. Zip Code

21632

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Navar Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Owner/Operator

16b. Kind of Business/Industry

Tavern/Trash Remov.

17. Father's Name (First, Middle, Last)

Elmer Bolden

18. Mother's Name (First, Middle, Maiden Surname)

Alice Cannon

19a. Informant's Name/Relationship (Type, Print)

Jeffrey Butler/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3401 Jefferson Pond Rd., Federalsburg, MD 21632

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Federal Hill Cemetery 2/22 Federalsburg, MD

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Michael F. Eskew

22. Name and Address of Facility

Framptom-Hawkins-Eskow Funeral Home  
PO Box 43, Federalsburg, MD 2163223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. CAD

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Hypertension, Diabetes Mellitus

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

48 hrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Mesenteric Ischemia &amp; Cecal Necrosis

End Stage Renal Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accidental 6 ☐ Could not be  
determined  
3 ☐ Suicidal 4 ☐ Homicidal28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Susan T. Forlifer MD

29c. License number

D 36919

29d. Date signed (Month, Day, Year)

2-17-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan T. Forlifer, MD, 505 Dutchmans Lane, Easton, MD 21601

31. Date filed (Month, Day, Year)

FEB 21 '97

32. Registrar's Signature

J. Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06125

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |                                 |  |
|---|---|--|---|--|--|---------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>PATRICIANN BERGSTRAZER  |  |   | 2. Date of Death<br>Month Day Year<br>Feb. 16, 1997  |  | 3. Time of Death<br>11:00 a.m.  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>902 B Gay Street  |  |   | 4b. City, Town, or Location of Death<br>Denton   |  | 4c. County of Death<br>Caroline |  |
| Funeral<br>Director   | 5. Social Security Number<br>180-34-2886  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>54 Yrs.  |                                 | 8. Date of Birth (Month, Day, Year)<br>10/28/42                                      |
|   | 9. Birthplace (State or Foreign Country)<br>Pennsylvania  |  | 10a. State<br>MD  |  | 10b. County<br>Caroline  |                                 | 10c. City, Town or Location<br>Denton  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br>902 B Gay Street  |  | 10f. Zip Code<br>21629   |                                 | 10g. Citizen of What Country?<br>United States                                       |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                 | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 1+   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |  | 16b. Kind of Business/Industry<br>Own Home   |                                 |  |
|   | 17. Father's Name (First, Middle, Last)<br>Charles Kruss  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Louise  |  |                                 |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Norman Bergstrazer/spouse   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>902B Gay Street, Denton, MD 21629 |  |                                 |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Bloomery Cemetery   |  | Date<br>2/20   |                                 | 20c. Location - City or Town, State<br>Federalsburg, MD                              |
|   | 21. Signature of Funeral Service Licensee<br>Michael F. Glem  |  |   | 22. Name and Address of Facility<br>Frampton-Hawkins-Eskow Funeral Home<br>PO Box 43, Federalsburg, MD 21632                       |  |                                 |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. Myocardial Infarction Due to (or as a consequence of):<br>b. Cardiomyopathy Due to (or as a consequence of):<br>c. Coronary Artery Disease Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br>1 Day<br>+ 5 years<br>+ 5 years |  |   |  |  |                                 |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br>IDDM, Pathologic Fracture Leg,<br>Diabetic Gastroparesis, Peripheral<br>Vascular Disease, Retinopathy   |  |   |  |  |                                 |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |  |  |                                 |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  |  |                                 |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |  |  |                                 |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.<br>Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |                                 |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |                                 | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |  |  |                                 |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |                                 |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |                                 |  |
|   | 29b. Signature and title of certifier<br>[Signature]  |  | 29c. License number<br>D33294   |  | 29d. Date signed (Month, Day, Year)<br>2/18/97   |                                 |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>920 Market St. Denton, Md. 21629 Rob Lappin MD  |  |   |  |  |                                 |  |
|   | 31. Date filed (Month, Day, Year)<br>FEB 18 '97   |  | 32. Registrar's Signature<br>Julia Davidson-Wendell   |  |  |                                 |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06126

## Certificate of Death

Reg. No.

|   |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>HENRIETTA LUCILLE BENTON   |  |  |  | 2. Date of Death<br>Month: Feb. Day: 16 Year: 1997   |  | 3. Time of Death<br>12:18PM   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Physicians Memorial Hospital   |  |  |  | 4b. City, Town, or Location of Death<br>Laplat   |  | 4c. County of Death<br>Charles  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>579-48-5658   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>62 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>May 13, 1934   |  |
|   | 9. Birthplace (State or Foreign Country)<br>WashingtonDC   |  | 10a. State<br>Maryland   |  | 10b. County<br>Charles   |  | 10c. City, Town or Location<br>LaPlata  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>8722 Cooksey Road  |  | 10f. Zip Code<br>20646   |  | 10g. Citizen of What Country?<br>United States  |  |
|   | 11. Marital Status<br>XX Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>9th  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Operating Room Tech   |  | 16b. Kind of Business/Industry<br>Southern Maryland Hospital   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Joseph Karis  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Marie Herring   |  | 19a. Informant's Name/Relationship (Type, Print)<br>Donna Lee Conrad   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8722 Cooksey Road, LaPlata, Maryland 20646   |  |
| Physician<br>/Medical<br>Examiner             | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Trinity Memorial Gardens   |  | 20c. Location - City or Town, State<br>Waldorf, Maryland   |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>Charles L. Belanger   |  | 22. Name and Address of Facility<br>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. CONGESTIVE HEART FAILURE<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br>Many years |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>END STAGE RENAL FAILURE<br>DEEP VENOUS THROMBOSIS<br>HYPERTENSION   |  | 23c. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Location (Street and Number or Rural Route Number, City or Town, State) |  |
| State Registrar                               | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>V. Anmangandla  |  | 29c. License number<br>D-26064   |  | 29d. Date signed (Month, Day, Year)<br>2-16-97  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Vidyasagar Anmangandla, MD   |  | 31. Date filed (Month, Day, Year)<br>FEB 20 1997   |  | 32. Registrar's Signature<br>John Davidson Randall   |  |   |  |

Baltimore, Maryland 21215-0020

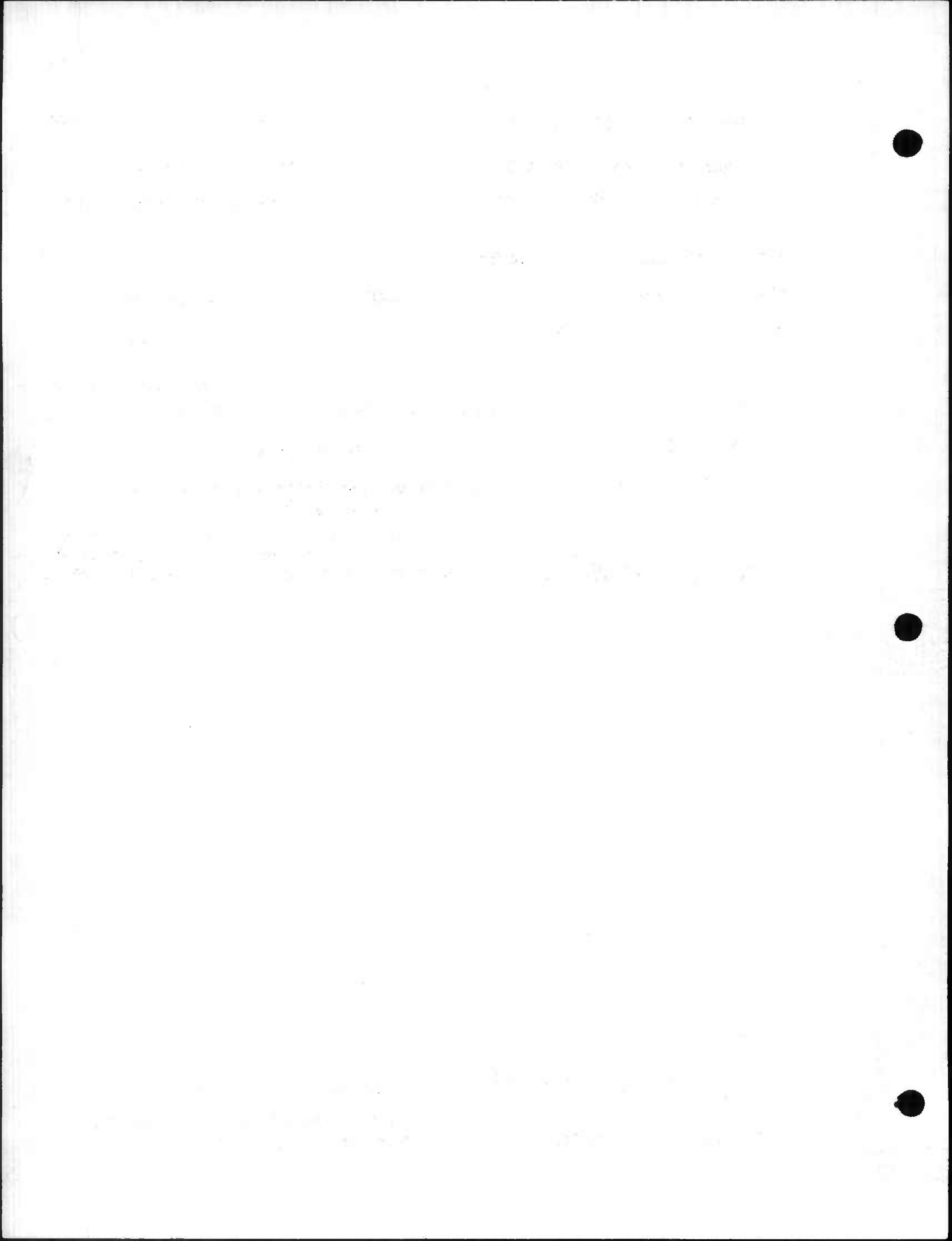
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06127

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CATHERINE

BECKER

2. Date of Death

FEB 06

1997

3. Time of Death

7.00 PM

4a. Facility Name (If not institution, give street and number)

SACRED HEART HOME

4b. City, Town, or Location of Death

HYATTSVILLE MD

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

236-20-3515

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 21, 1913

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5805 Queens Chapel Road

10f. Zip Code

20782

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

Grade 12

College (1-4 or 5+)

4 years

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Samuel Bracken

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Coughlan

19a. Informant's Name/Relationship (Type, Print)

Joseph Becker / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5007 Cheyenne Place College Park, Maryland 20740

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Calvary Cemetery

Date

2/10/97

20c. Location - City or Town, State

Wheeling, W.VA.

21. Signature of Funeral Service Licensee

Donaldson Funeral Home, P.A.

22. Name and Address of Facility

313 Talbott Avenue Laurel, Maryland 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Aspiration pneumonia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 days

b. Senile dementia

Due to (or as a consequence of):

years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus Type II

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation  
6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Peter M. Schwiler MD

29c. License number

D22780

29d. Date signed (Month, Day, Year)

2/7/97

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

Peter M Schwiler MD 7500 Greenway Ctr. Dr. Greenbelt Md 20770

31. Date filed (Month, Day, Year)

32. Registrar's Signature

▶

State  
Registrar

Baltimore, Maryland 21215-0020

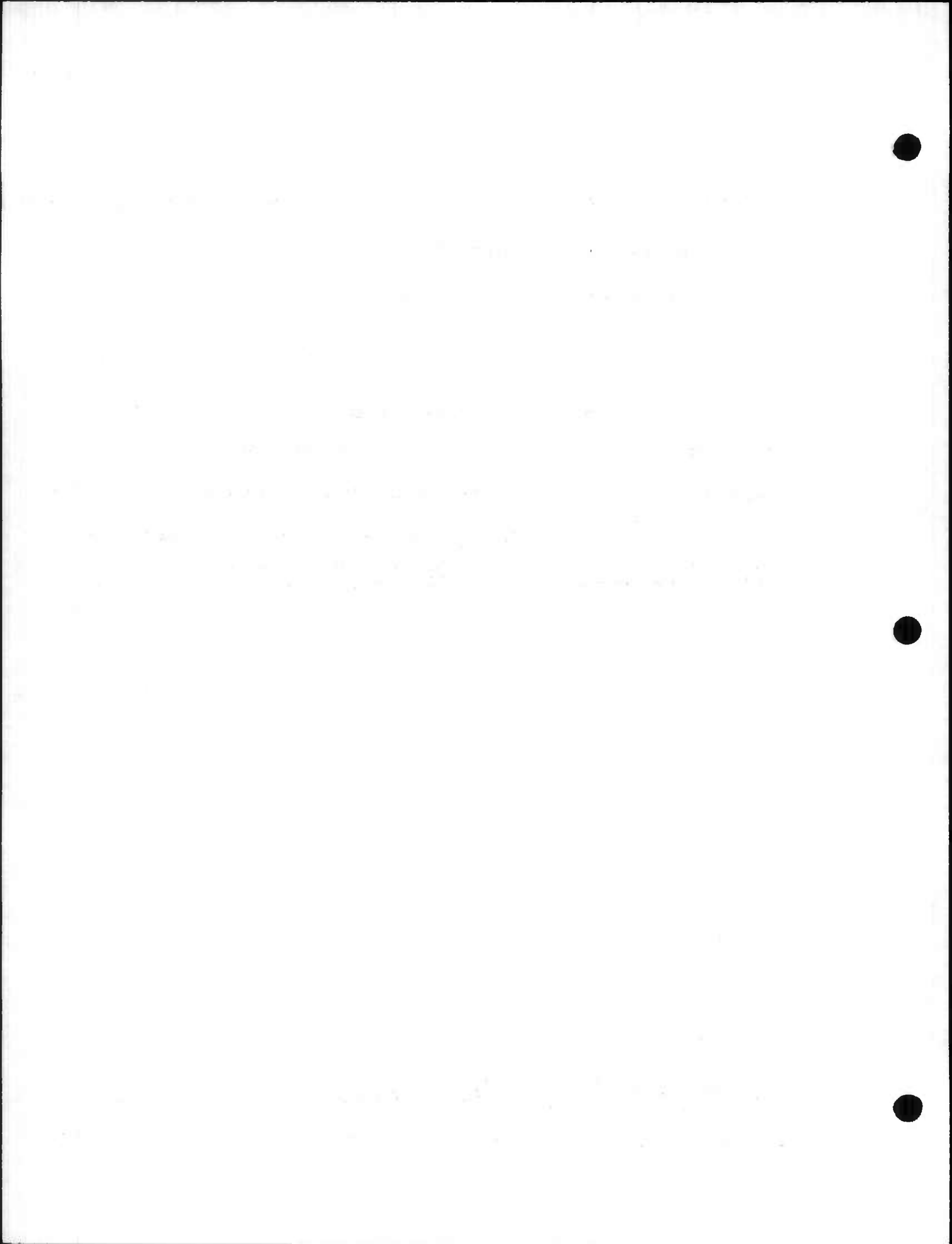
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



97 06128

1. Decedent's Name (First, Middle, Last) Sandra Robinson Ballard

2. Date of Death February 7, 1997

3. Time of Death 0129

4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death SALISBURY

4c. County of Death WICOMICO

5. Social Security Number

6. Sex 1 Male 2 Female 3

7. Age (In yrs. last birthday) 46 Yrs.

8. Date of Birth 8-22-51

9. Birthplace (State or Foreign Country) Maryland

10a. State md

10b. County Wicomico

10c. City, Town or Location Suitland

10d. Inside City Limits 1 Yes 2 No

11. Merit Status 1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No

13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 Yes 2 No

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook

16b. Kind of Business/Industry Salisbury State College

17. Father's Name (First, Middle, Last) Milbourne Robinson

18. Mother's Name (First, Middle, Maiden Surname) Sarah Cathrine Jones Robinson

19a. Informant's Name/Relationship (Type, Print) Selina Robinson Hopkins

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 503 N. Division St Suitland md 21861

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) St. James Tree Cemetery

20c. Location - City or Town, State 7/5/97 Head & Neck md

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Brady arrhythmia

23b. Approximate Interval Between Onset and Death Hours

23c. Due to (or as a consequence of): Splanchnic Vessel Disease

23d. Due to (or as a consequence of):

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06129

## Certificate of Death

Reg. No.

|   |   |  |  |                                |  |
|---|---|--|--|--------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>STELLA H. BRITTINGHAM</b>  |  | 2. Date of Death<br>Month <b>FEB.</b> Day <b>12</b> Year <b>1997</b>   |                                | 3. Time of Death<br><b>3:10 PM</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Salisbury Center, Genesis ElderCare</b>  |  | 4b. City, Town, or Location of Death<br><b>Salisbury, Md.</b>  |                                | 4c. County of Death<br><b>Wicomico</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-36-5804</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>MAR. 3 1906</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MD.</b>   |                                |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  |  |                                |  |
|   | 10a. State<br><b>MD.</b>  | 10b. County<br><b>WICOMICO</b>   | 10c. City, Town or Location<br><b>SALISBURY</b>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>113 ROSEBERRY AVENUE</b>   |  | 10f. Zip Code<br><b>21804</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>                        |                                |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TEACHER</b>   |  | 16b. Kind of Business/Industry<br><b>PUBLIC SCHOOLS</b>  |                                |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>ASHER LEE HEARNE</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ALLIE PERDUE</b>   |                                |  |
|   | 19e. Informant's Name/Relationship (Type, Print)<br><b>GLADYS FIGGS-SISTER</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>113 ROSEBERRY AVENUE, SALISBURY, MD. 21804</b> |                                |  |
|   | 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>PARSONS CEMETERY</b>  |                                | 20c. Location - City or Town, State<br><b>2/15/97 SALISBURY, MD.</b>   |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>BOUNDS FUNERAL HOME, SALISBURY, MD. 21804</b>   |                                |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Stroke</b>            |  |  |                                | Approximate Interval Between Onset and Death<br><b>7 Days</b>  |
|   | Immediate Cause (Final disease or condition resulting in death)<br><b>Stroke</b>  |  |  |                                |  |
|   | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   |  |  |                                |  |
|   | Due to (or as a consequence of):  |  |  |                                |  |
|   | Due to (or as a consequence of):  |  |  |                                |  |
|   | Due to (or as a consequence of):  |  |  |                                |  |
|   | Due to (or as a consequence of):  |  |  |                                |  |
|   | Due to (or as a consequence of):  |  |  |                                |  |
|   | Due to (or as a consequence of):  |  |  |                                |  |
|   | Due to (or as a consequence of):  |  |  |                                |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Multi infarct Dementia</b>   |   |  |  |                                |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |  |                                |  |
| 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |                                |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |                                |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |                                |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |  |                                |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   |  |  |                                |  |
| 28a. Date of Injury (Month, Day Year)   |   |  |  |                                |  |
| 28b. Time of Injury<br><b>M</b>   |   |  |  |                                |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |                                |  |
| 28d. Describe how injury occurred   |   |  |  |                                |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  |                                |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |                                |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |                                |  |
| 29b. Signature and title of certifier<br>  |   |  |  |                                |  |
| 29c. License number<br><b>D-39813</b>   |   |  |  |                                |  |
| 29d. Date signed (Month, Day, Year)<br><b>2/14/97</b>   |   |  |  |                                |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD. 21804</b>   |   |  |  |                                |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 14 1997</b>   |   |  |  |                                |  |
| 32. Registrar's Signature<br>  |   |  |  |                                |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10

State  
Registrar





97 06130

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Corinne Camden Cooper</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 10 1997</b>  |  | 3. TIME OF DEATH<br><b>9:25 a.m.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>579-60-7037</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>96 YRS.</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>8/8/1900</b>  |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Hartley Hall Nursing Home, Inc.</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Pocomoke City</b>   |  | 9c. COUNTY OF DEATH<br><b>Worcester</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Somerset</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Pocomoke City</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>1570 Pocomoke River Road</b>   |  |  |  | 10f. ZIP CODE<br><b>21851</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 8+) <b>0</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Elvis Camden</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Eva Findley</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>James L. Sanders</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7570 Pocomoke River Rd., Pocomoke, Md. 21851</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Beechwood Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>1/2 Princess Anne, Md.</b>  |  | 20d. DATE   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Scott S. Melson</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Melson Funeral Home<br/>P.O. Box 64, Pocomoke, Md. 21851</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  | a. <b>Arteriosclerotic Heart Disease</b>   |  |   |  |   | Approximate interval Between Onset and Death<br><b>1 yr.</b> |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  | b. <b>Generalized Atherosclerosis</b>  |  |   |  |   | <b>5 yrs.</b>  |
|   |  | c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|   |  | d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive Heart Failure; Coronary Artery Disease; Anemia; Deep Vein Thrombosis; Recent M.I.</b>   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|   |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  |   |  |   |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Gregorio M. Belloso M.D.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 29505</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2-10-97</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>GREGORIO M. BELLOSO, M.D. 5302 CHINABERRY DR., SALISBURY, MD 21801</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 14 1997</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Andrew Raskall</b>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06131

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |                                |  |  |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>HELEN PAULINE CROUSE</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 16, 1997</b>   |                                | 3. Time of Death<br><b>8:15 AM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>ST. CATHERINE'S NURSING HOME</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>EMMITSBURG</b>  |                                | 4c. County of Death<br><b>FREDERICK</b>  |  |
| 5. Social Security Number<br><b>218-50-7087</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>NOV. 13, 1912</b>                          |  |
| 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  |   |  |  |                                |  |  |
| 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>CARROLL</b>   |  | 10c. City, Town or Location<br><b>TANEYTOWN</b>  |                                |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 10e. Street and Number<br><b>37 YORK STREET</b>   |  |   |  | 10f. Zip Code<br><b>21787</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>CAUCASIAN</b>          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>  |                                | 16b. Kind of Business/Industry<br><b>DOMESTIC</b>                                    |  |
| 17. Father's Name (First, Middle, Last)<br><b>CLARENCE F. BAUMGARDNER</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LUCY REAVER</b>  |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>KENNETH D. CROUSE SON</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>HARNEY ROAD TANEYTOWN, MARYLAND 21787</b>  |                                |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GRACE UNITED CHURCH OF CHRIST</b>  |  | 20c. Location - City or Town, State<br><b>TANEYTOWN, MARYLAND</b>  |                                | 20d. Date of Disposition<br><b>2/19/97</b>   |  |
| 21. Signature of Funeral Service Licensee<br><i>John M. Skiles</i>  |  |   |  | 22. Name and Address of Facility<br><b>136 EAST BALTIMORE STREET<br/>SKILES FUNERAL HOME TANEYTOWN, MARYLAND 21787</b>   |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death) <b>CVA</b><br>a. Due to (or as a consequence of):<br>b. <b>Carcinoma of the Uterus</b><br>c. <b>Chronic Lymphatic Leukemia</b><br>d. <b>25 yrs</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |                                |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |  |  |                                |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |                                |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |  |                                |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHF, pneumonia</b>   |  |   |  |  |                                |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |                                |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred  |                                |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |                                |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |                                |  |  |
| 29b. Signature and title of certifier<br><i>Wenifredo N. Iglesias</i>   |  |   |  | 29c. License number<br><b>PD 8914</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 17, 1997</b>                      |  |
| 30. Name and address of person who completed cause of death (from 23a) (Type, Print)<br><b>WENIFREDO N. IGLESIA, M.D. 49 FREDERICK STREET TANEYTOWN, MARYLAND 21787</b>   |  |   |  |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 18 1997</b>   |  |   |  | 32. Registrar's Signature<br><i>Nuclear-Rodall</i>   |                                |  |  |

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06132

Pauline Helen Crampton

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Pauline Crampton

2. Date of Death

Month Day Year  
February 12 1997

3. Time of Death

1410

4a. Facility Name (If not institution, give street and number)

Homewood Retirement Center

4b. City, Town, or Location of Death

Williamsport

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

218-30-9435

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
January 31, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☐ Yes 2 ☐ No

10e. Street and Number

11 W. Baltimore Street

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

home

17. Father's Name (First, Middle, Last)

Frank Clayton Nigh

18. Mother's Name (First, Middle, Maiden Surname)

Harriett Louise Metz

19a. Informant's Name/Relationship (Type, Print)

Holland R. Nigh

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

307 Garlinger Avenue Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hagerstown Crematory

Date

2/18/97

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Gerald N. Minnich

22. Name and Address of Facility

Gerald N. Minnich  
Funeral Home

305 N. Potomac Street

Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic cerebrovascular disease  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dehydration  
Aspiration

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D26806

29d. Date signed (Month, Day, Year)

2/18/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anderson 747 Nathan Ave Hagerstown MD 21742

31. Date filed (Month, Day, Year)

32. Registrar's Signature

FEB 19 1997

John Anderson

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

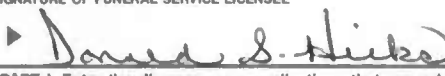
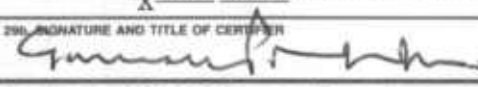

State  
Registrar



97 06133

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>George Allen Clark</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>Feb</b> DAY <b>9th</b> YEAR <b>1997</b>  |  | 3. TIME OF DEATH<br><b>16=37HrM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>222-36-2145</b>  |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <b>2</b> <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>46</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>June 28, 1950</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Delaware</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>215 S. Union Ave</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Havre De Grace</b>  |  | 9c. COUNTY OF DEATH<br><b>Harford</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Harford</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Havre de Grace</b>  |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>215 S. Union Ave.</b>   |  |  |  | 10f. ZIP CODE<br><b>21078</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |
| 11. MARITAL STATUS<br><b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Nurses Assistant</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Medical</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Marshall A. Clark</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Jean F. Parvis</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Jean F. Megargee (Mother)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>43 Anchor Way, Berlin, MD. 21811</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>DE. Vets. Mem. Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>2/13/1997 Bear, DE.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hicks Home for Funerals, P.A.<br/>103 W. Stockton St., Elkton, MD. 21921</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Deep Neck wound - cut corotid artery RT</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Self Inflicted</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d. DUE TO (OR AS A CONSEQUENCE OF):</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO  |  |  |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input checked="" type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>2-9-97</b>  |  | 28b. TIME OF INJURY<br><b>NK</b> M  |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO     |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>self inflicted cut-Knife</b>   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>215 S. Union Ave Havre De</b>  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>Grace</b><br><b>2</b> <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>DME</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>OCME</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2-10-97</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>G.S. Prabhu M.D. 1810 Belair Rd # 102 Fallston MD. 21047 410-879-6564</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 12 1997</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06134

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Oscar K. Comer

2. Date of Death

February 16 1997

3. Time of Death

1340

4a. Facility Name (If not institution, give street and number)

Union Hospital of Cecil County

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

215-16-7460

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

December 8, 1912

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Rising Sun

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

41 Bracken Lane

10f. Zip Code

21911

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

4

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

farmer

16b. Kind of Business/Industry

self-employed

17. Father's Name (First, Middle, Last)

James F. Comer

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Sedella Kegly

19a. Informant's Name/Relationship (Type, Print)

Mabel J. Comer / Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

41 Bracken Lane, P. O. Box 716, Rising Sun, MD 21911

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

New Bridge Baptist Cem.

Date

Feb. 19

20c. Location - City or Town, State

Rising Sun, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Crouch Funeral Home

127 South Main Street, North East, MD 21901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. metastatic Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D-32395

29d. Date signed (Month, Day, Year)

February 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Finucan, M.D., 3 Mauldin Avenue, North East, MD 21901 410-287-6616

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitComer, Oscar Kemp  
Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06135

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HARRY S. CARROLL JR.

2. Date of Death

Month Day Year  
FEBRUARY 19 1997

3. Time of Death

1:39 Am

4a. Facility Name (If not institution, give street and number)

SOUTHERN MARYLAND HOSPITAL

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

218-16-0683

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 21, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9950 Rosaryville Road

10f. Zip Code

20772

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1943-

1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

Collage (1-4 or 5+)

N/A

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Fireman

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Harry S. Carroll, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Emma C. Barry

19a. Informant's Name/Relationship (Type, Print)

Ronald L. Carroll (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9960 Rosaryville Rd. Upper Marlboro, Maryland 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland State Veterans Cem. 1997

Date

Feb. 21,

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

Charles L. Belanger

22. Name and Address of Facility

Lee Funeral Home, Inc.  
6633 Old Alexandria Ferry Rd. Clinton, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARCINOMA OF LUNG WITH METASTASES 6 WEEKS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

INTERSTITIAL LUNG DISEASE

CHRONIC OBSTRUCTIVE LUNG DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Louis Kaufman

29c. License number

D/2906

29d. Date signed (Month, Day, Year)

2/19/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

LOUIS KAUFMAN 8926 WOODYARD RD CLINTON MD 20735

31. Date filed (Month, Day, Year)

FEB 20 1997

32. Registrar's Signature

Julia Anderson Randall

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



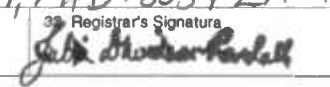
State of Maryland / Department of Health and Mental Hygiene

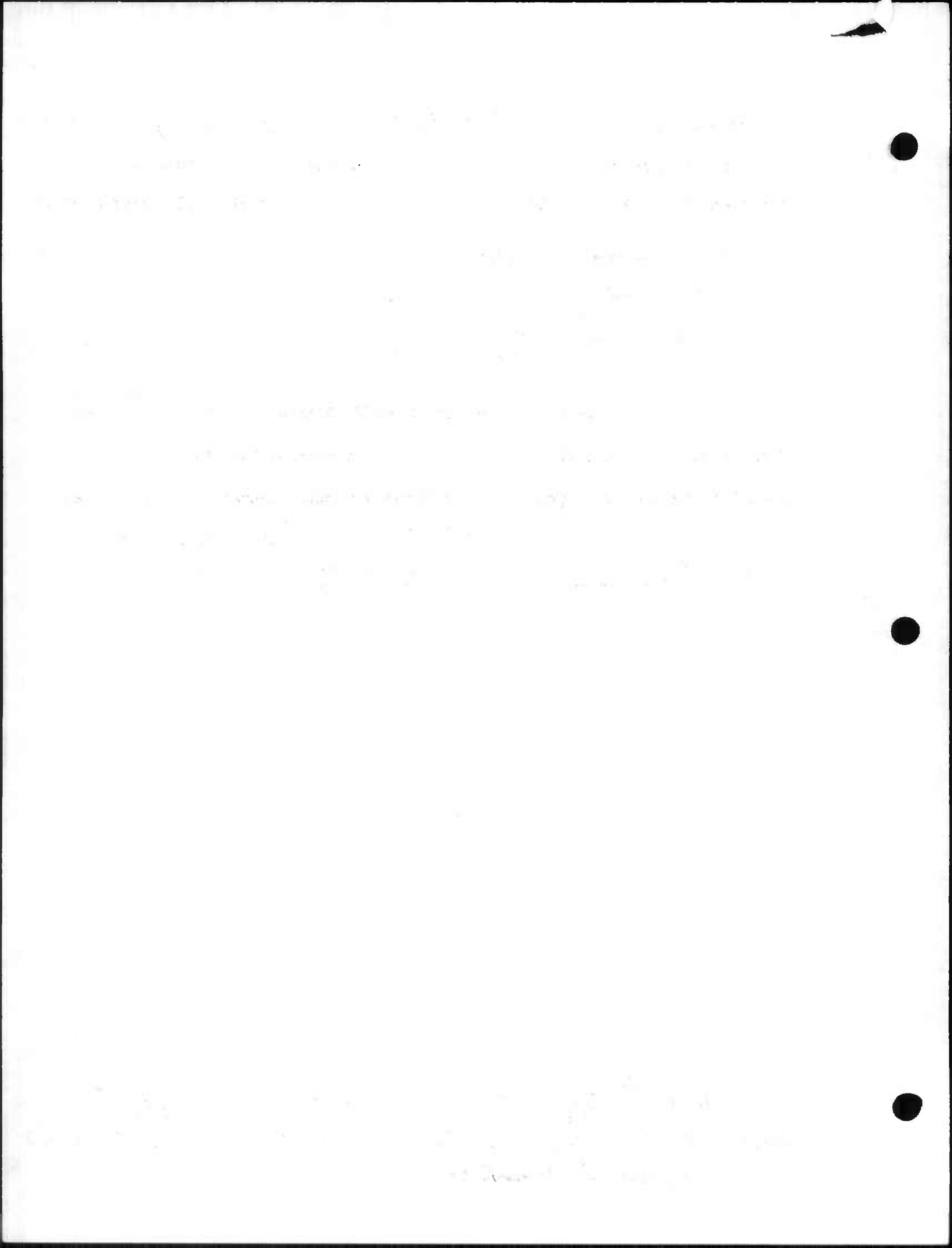
97 06136

Amended #23a Part II, 2/10/97, PCT, Howard

Certificate of Death

Reg. No.

|   |   |  |  |                                |  |  |   |   |
|---|---|--|--|--------------------------------|--|--|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MICHAEL JOSEPH CANNON</b>  |  |  |                                | 2. Date of Death<br>Month <b>FEB</b> Day <b>6</b> Year <b>97</b>   |  | 3. Time of Death<br><b>1-15 A.M.</b>                                    |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>3347 Cranberry South</b>   |  |  |                                | 4b. City, Town, or Location of Death<br><b>Laurel</b>  |  | 4c. County of Death<br><b>Anne Arundel</b>                              |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>191-26-7983</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Oct 21, 1935</b>                                     |   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b> |
|   | Usual Residence of Decedent   |  |  |                                |  |  |   |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Anne Arundel</b>   | 10c. City, Town or Location<br><b>Laurel</b>   |                                |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   |
|   | 10e. Street and Number<br><b>3347 Cranberry South</b>   |  |  | 10f. Zip Code<br><b>20724</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1954-</b><br>If Yes, Give Year or Dates: <b>1956</b> |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2 years</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Assistant Public Printer</b>                               |                                | 16b. Kind of Business/Industry<br><b>U.S. Government Printing Office</b>   |  |   |   |
| To Be Completed by Physician/Medical Examiner   | 17. Father's Name (First, Middle, Last)<br><b>Michael Joseph Cannon, Sr.</b>  |  |  |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine Sabatini</b>   |  |   |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Rachel A. Cannon / spouse</b>  |  |  |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3347 Cranberry South Laurel, Maryland 20724</b>  |  |   |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Mary's Church Cem.</b>  |                                | 20c. Location - City or Town, State<br><b>Laurel, Maryland</b>   |  | 20d. Date<br><b>Feb. 8, 1997</b>  |   |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Donaldson Funeral Home, P.A.<br/>313 Talbott Avenue Laurel, Maryland 20707</b>  |                                |  |  |   |   |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>CEREBRAL METASTASIS.</b><br>Due to (or as a consequence of):<br><b>PULMONARY METASTASIS.</b><br>Due to (or as a consequence of):<br><b>RENAL CELL CARCINOMA,</b><br>Due to (or as a consequence of):<br><b>14 years</b> |  |  |                                |  |  |   |   |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |                                |  |  |   |   |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |                                |  |  |   |   |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |                                |  |  |   |   |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPERTENSION.</b><br><b>DEGENERATIVE ARTHRITIS.</b>  |  |  |                                |  |  |   |   |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |                                |  |  |   |   |
|   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |                                |  |  |   |   |
|   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide  |  |  |                                |  |  |   |   |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.<br>Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once. | 28a. Date of Injury (Month, Day Year)   |  |  |                                |  |  |   |   |
|   | 28b. Time of Injury<br><b>M</b>   |  |  |                                |  |  |   |   |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |                                |  |  |   |   |
|   | 28d. Describe how Injury occurred   |  |  |                                |  |  |   |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |                                |  |  |   |   |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |                                |  |  |   |   |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                   |  |  |                                |  |  |   |   |
|   | 29b. Signature and title of certifier<br> M.D.   |  | 29c. License number<br><b>D 21294</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>2/7/97</b>   |  |   |   |
| State Registrar   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ABDUL NAYEEM, M.D. 8037 LAUREL LAKES COURT, LAUREL, M.D. 20707.</b>  |  |  |                                |  |  |   |   |
|   | 31. Date filed (Month, Day, Year)<br><b>FEB 10 1997</b>   |  |  |                                | 32. Registrar's Signature<br>   |  |   |   |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06137

Item 23b per PHY Film G745 3-18-97 rja

## Certificate of Death

Reg. No.

|  |   |  |  |  |   |   |  |   |   |   |  |
|--|---|--|--|--|---|---|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>LLOYD CAHALL</b>   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 7, 1997</b>   |   |  |   | 3. Time of Death<br><b>6:16 a</b>   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>   |   |  |   | 4c. County of Death<br><b>Baltimore</b>   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-32-0391</b>   |  | 6. Sex<br><b>1</b> M <b>2</b> F  | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.                             | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 11, 1933</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Greensboro, Md.</b>                                      |   |  |
|  | Usual Residence of Decedent   |  |  |  |   |   |  |   |   |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>De.</b>  |  | 10b. County<br><b>Sussex</b>   |  | 10c. City, Town or Location<br><b>Laurel</b>  |   |  |   | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No   |   |  |
|  | 10e. Street and Number<br><b>RD#4 Box 385</b>   |  |  |  | 10f. Zip Code<br><b>19956</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>                  |   |   |   |  |
|  | 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Custodian</b>                     |   |  | 16b. Kind of Business/Industry<br><b>School</b>                         |   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>John Cahall</b>   |  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bessie Hardsox Cahall</b> |  |   |   |   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mildred E. Cahall, Wife</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>RD#4 Box 385 Laurel, De. 19956</b>            |   |  |   |   |   |  |
|  | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greensboro Cemetery</b>   |  |   | Date<br><b>2-10-97</b>  |  | 20c. Location - City or Town, State<br><b>Greensboro, Md.</b>           |   |   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>William M. Roth</i>   |  |  |  | 22. Name and Address of Facility<br><b>Short Funeral Home, Inc.<br/>700 W. St. Laurel, De. 19956</b>  |   |  |   |   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. I SCHEMIC DILATED CARDIOMYOPATHY</b><br>Due to (or as a consequence of):<br><b>b. VENTRICULAR TACHYCARDIA</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |  |  |   |   |  |   |   | Approximate Interval Between Onset and Death<br><b>16 YEARS</b><br><b>4 MONTHS</b>                                    |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown |  |
| 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No   |   |  |  |  |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No |   |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No   |   | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |  |   |   |  |   |   |   |  |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending Investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide   |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No                                  |  | 28d. Describe how injury occurred                                       |   |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |  |   |   |   |  |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |  |   |   |  |   |   |   |  |
| 29b. Signature and Title of certifier<br><i>[Signature]</i> M.D.   |   |  |  |  | 29c. License number<br><b>RES-000</b>   |   |  | 29d. Date signed (Month, Day, Year)<br><b>02/07/97</b>                  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>600 N. WOLFE ST., BALTIMORE, MD. 21287</b>  |   |  |  |  |   |   |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 11 1997</b>  |   |  |  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |   |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06138

Reg. No.

|  |  |  |   |  |  |  |   |  |  |  |
|--|--|--|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>LEONARD H. DIEHL</b>  |  |   |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>16</b> Year <b>1997</b>   |  |   |  | 3. Time of Death<br><b>2308</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>ATLANTIC GENERAL HOSPITAL</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>BERLIN</b>  |  |   |  | 4c. County of Death<br><b>WORCESTER</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>142-12-9018</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>4-26-17</b>             |  | 9. Birthplace (State or Foreign Country)<br><b>PA.</b>   |  |
|  | Usual Residence of Decedent  |  |   |  |  |  |   |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD.</b>   |  | 10b. County<br><b>WORCESTER</b>   |  | 10c. City, Town or Location<br><b>BERLIN</b>   |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>240 OCEAN PARKWAY</b>   |  |   |  | 10f. Zip Code<br><b>21811</b>  |  |   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SUPERINTENDENT</b>   |  |   |  | 16b. Kind of Business/Industry<br><b>STEEL</b>   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>LEONARD H. DIEHL, SR.</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>HELEN GARVER</b>   |  |   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>ALICE K. DIEHL</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2672 OCEAN PINES BERLIN, MD., 21811</b>  |  |   |  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>SALISBURY CREMATORY</b>   |  | 20c. Location - City or Town, State<br><b>2-17 SALISBURY, MD.</b> |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |   |  | 22. Name and Address of Facility<br><b>ULLRICH FUNERAL HOME BERLIN, MD., 21811</b>   |  |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <i>congestive heart failure</i></p> <p>Due to (or as a consequence of):</p> <p>b. <i>2nd or 3rd degree heart block</i></p> <p>Due to (or as a consequence of):</p> <p>c. _____</p> <p>Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> <p>a. <i>3 yrs</i></p> <p>b. <i>1 day</i></p> <p>c. _____</p> <p>d. _____</p> </div> </div> |  |   |  |  |  |   |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |   |  |  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |  |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |  |  |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |   |  |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |  |   |  |  |  |   |  |  |  |
| 28a. Date of Injury (Month, Day, Year)   |  |  |   |  |  |  |   |  |  |  |
| 28b. Time of Injury<br><b>M</b>  |  |  |   |  |  |  |   |  |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |  |  |   |  |  |  |
| 28d. Describe how injury occurred  |  |  |   |  |  |  |   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |  |  |  |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |  |  |  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i><br><b>physician</b>  |  |  |   |  |  |  |   |  |  |  |
| 29c. License number<br><b>1444283</b>  |  |  |   |  |  |  |   |  |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>2/17/97</b>  |  |  |   |  |  |  |   |  |  |  |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>Robert Dyer 9233 Herlitz way Drive Berlin, MD</b>   |  |  |   |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 18 1997</b>  |  |  |   |  |  |  |   |  |  |  |
| 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |   |  |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06139

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Charles Joseph Dubrowa

2. Date of Death

February 12, 1997

3. Time of Death

12:30 PM

4a. Facility Name (If not institution, give street and number)

Reeders Memorial Home

4b. City, Town, or Location of Death

Boonsboro

4c. County of Death

Washington

5. Social Security Number

468-10-2694

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 6, 1918

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Boonsboro

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

141 South Main Street

10f. Zip Code

21713

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Steelworker

16b. Kind of Business/Industry

Steel Manufacturing

17. Father's Name (First, Middle, Last)

John DuBrowa

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Charles DuBrowa

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

475 New York Avenue, Rochester, PA 15074

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sylvania Hills Cemetery

Date

02/15/97

20c. Location - City or Town, State

Rochester, PA

21. Signature of Funeral Service Licensee

P. Steven Danfelt, Jr.

22. Name and Address of Facility

7606 Old National Pike  
BAST FUNERAL HOME Boonsboro, MD 21713

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia  
Due to (or as a consequence of):

3 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Aspiration  
Due to (or as a consequence of):

4 weeks

c. Dementia  
Due to (or as a consequence of):

unknown

d. Senility  
Due to (or as a consequence of):

-

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

P. Steven Danfelt, Jr.

29c. License number

D44996

29d. Date signed (Month, Day, Year)

Feb 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Zafar Malik 20311 Lappans Road, Boonsboro, Maryland 21713/301-432-8470

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

John Sturges-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06140

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LUCILLE ELAINE DETROW

2. Date of Death

February 14, 1997

3. Time of Death

1:20 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

20833 Mt. Aetna Road

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

217-10-3412

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 4, 1916

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

20833 Mt. Aetna Road

10f. Zip Code

21742

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Personal Residence

17. Father's Name (First, Middle, Last)

Robert Fred Forkner

18. Mother's Name (First, Middle, Maiden Surname)

Beulah N. Ashburn

19a. Informant's Name/Relationship (Type, Print)

Dale R. Detrow, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20809 Mt. Aetna Road, Hagerstown, Maryland 21742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Beaver Creek Cemetery 02/17/97

Date

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

P. Steven Danfelt, Jr. MD1093

22. Name and Address of Facility

BAST FUNERAL HOME 7606 Old National Pike  
Boonsboro, MD 21713

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Epithelial Cell malignancy abdomen  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

none

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

NA

28b. Time of injury

NA

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N/A

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Allan J. Gray

29c. License number

D 28365

29d. Date signed (Month, Day, Year)

2-15-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MANZAR J SHAM 368 MILLS STREET HAGERSTOWN 21740

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

John A. Ruckelshaus

Baltimore, Maryland 21215-0020

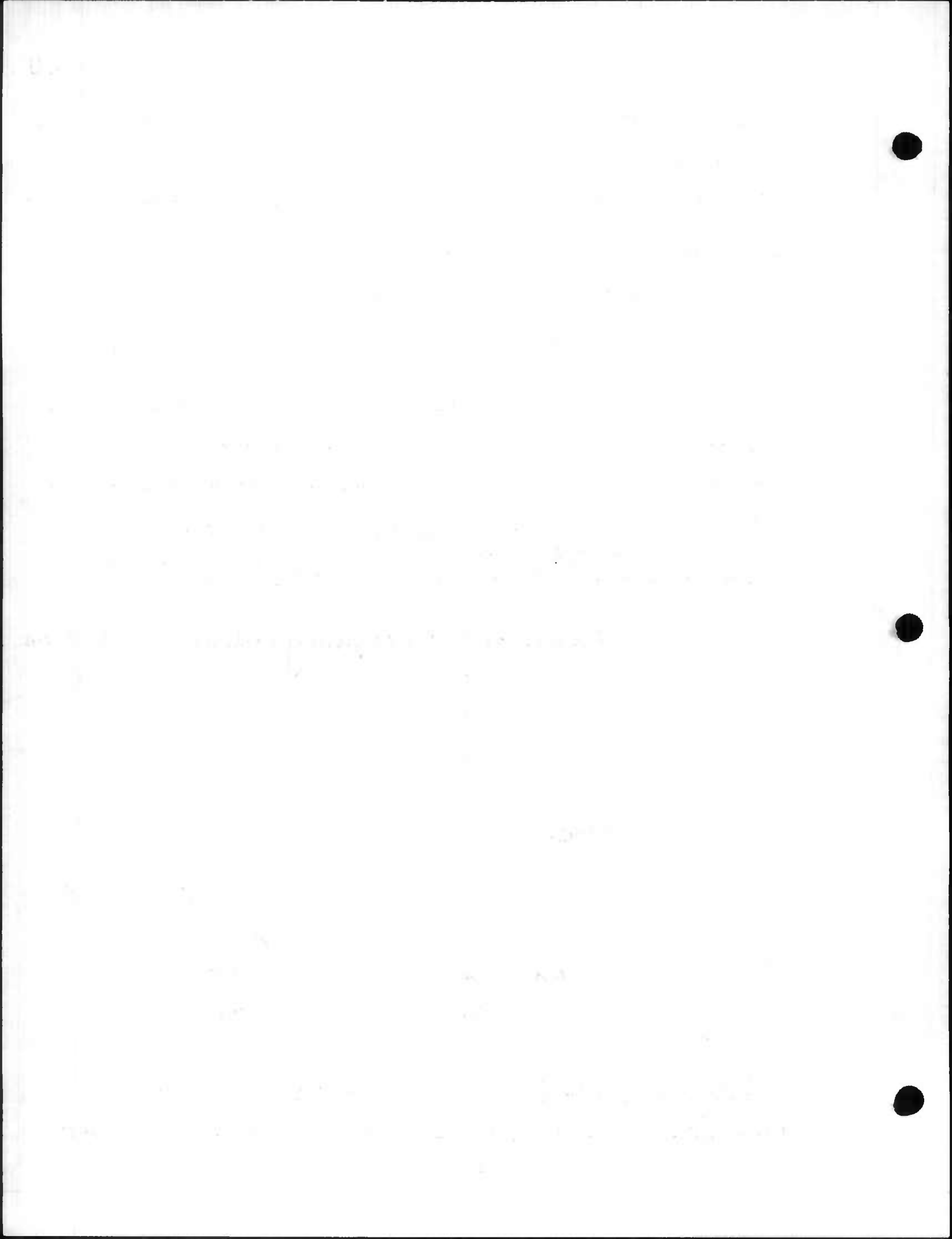
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06141

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

GERALDINE VIRGINIA DETROW

2. Date of Death

February 17 1997

3. Time of Death

8:15PM

4a. Facility Name (If not institution, give street and number)

WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death

HAGERSTOWN

4c. County of Death

WASHINGTON

5. Social Security Number

220-46-1321

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

OCT. 23, 1914

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WASHINGTON

10c. City, Town or Location

BOONSBORO

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8213 MAPLEVILLE ROAD

10f. Zip Code

21713

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

JANE KENNEDY

19a. Informant's Name/Relationship (Type, Print)

RONALD E. DETROW/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8223 MAPLEVILLE ROAD, BOONSBORO, MARYLAND 21713

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BEAVER CREEK CEMETERY

Date

2/20/97

20c. Location - City or Town, State

BEAVER CREEK, MARYLAND

21. Signature of Funeral Service Licensee

Paul M. Dean

22. Name and Address of Facility

BAST FUNERAL HOME

7606 Old National Pike

Boonsboro, Maryland 21713

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. SEPSIS

Due to (or as a consequence of):

b. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

2 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End stage kidney disease;  
Amputation right leg; Depression

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury

(Month, Day Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Eli Raza

29c. License number

D22313

29d. Date signed (Month, Day, Year)

2-18-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eli Raza MD WASHINGTON COUNTY HOSPITAL

31. Date filed (Month, Day, Year)

FEB 19 1997

32. Registrar's Signature

John Andrew Barker

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit order.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





97 06142

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>WALTER N. DONOPHAN, SR.  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>02 10 1997  |  | 3. TIME OF DEATH<br>8:00 P. M.  |   |
| 4. SOCIAL SECURITY NUMBER<br>222-16-6973   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>67 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>JAN 30 1930  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>DEVLIN MANOR NURSING HOME  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>CUMBERLAND   |  | 9c. COUNTY OF DEATH<br>ALLEGANY   |   |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |   |
| 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>ALLEGANY   |  | 10c. CITY, TOWN OR LOCATION<br>CUMBERLAND   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>12116 C MCMILLAN HIGHWAY   |  |   |  | 10f. ZIP CODE<br>21502  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>KOREAN |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                                    |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>TRUCK DRIVER                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>TRUCKING  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>NELSON C. DONOPHAN  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>DELEMA AUSTIN  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>RICHARD DONOPHAN   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>37 VIRGINIA AVE, CUMBERLAND, MD 21502  |  |   |   |
| 20a. MANNER OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>HOPKINS CEMETERY   |  | 20c. LOCATION — City or Town, State<br>2-14 FELTON, DE  |  | 20d. DATE<br>2-14   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Ray M. Short</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>SHORT FUNERAL SERVICES INC<br>PO BOX 233, MILTON, DE 19968  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <i>Myocardial infarction</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Congestive heart failure</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br><i>approx. 1 hr</i><br><i>1 day</i>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>no infection against death; stroke; congestive heart failure</i><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John A. Bell</i>   |  |   |  | 29c. LICENSE NUMBER<br>D17565   |  | 29d. DATE SIGNED (Month, Day, Year)<br>Feb. 11, 1997  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>A J Bell 955 Frederick St Cumberland MD 21502   |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>FEB 14 1997   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. Bell</i>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06143

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Elizabeth English

2. Date of Death

Month Day Year

February 13, 1997 8:30A.M.

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

212-24-6335

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) Mar. 22, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Washington

10c. City, Town or Location

Smithsburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12 Blue Mt. Estates

10f. Zip Code

21783

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Charles Moats

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Day

19a. Informant's Name/Relationship (Type, Print)

Mary J. Humelsine (daughter) 17703 Winterberry Rd. Hagerstown, Md. 21740

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Feb. 17, 1997 Cedar Lawn Memorial Park

20c. Location - City or Town, State

Hagerstown, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrest

Due to (or as a consequence of):

b. Atrial Failure

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

24 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D38471

29d. Date signed (Month, Day, Year)

2/13/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.B. Keane 22911 Jefferson Blvd Smithsburg Md

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06144

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Cornell Ebanks

2. Date of Death  
Month Day Year  
February 17, 19973. Time of Death  
1:00 a.m.

4a. Facility Name (If not institution, give street and number)

Edw.W.McCready Memorial Hospital

4b. City, Town, or Location of Death

Crisfield

4c. County of Death

Somerset

Funeral  
Director

5. Social Security Number

217-09-2081

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 1 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Somerset

10c. City, Town or Location

Crisfield

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

201 Hull Hwy

10f. Zip Code

21817

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

Collega (1-4or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Disabled

16b. Kind of Business/Industry

Never Worked

17. Father's Name (First, Middle, Last)

Cornell D. Ebanks Sr.

18. Mother's Name (First, Middle, Maiden Sumama)

Marie Lloyd

19a. Informant's Name/Relationship (Type, Print)

Mary A. Banks

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

534 Biddle St. Chesapeake City MD 21915

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Bethel Cemetery Feb 19, 1997

Data

20c. Location - City or Town, State

Chesapeake City MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

R. T. Foard Funeral Home, P.A.

318 George St. Chesapeake City MD 21915

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a.

Artherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

b.

COPD

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D48098

29d. Date signed (Month, Day, Year)

2/17/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vijay Karumbunthan, M.D. - 201 Hall Highway - Crisfield, MD 21817

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06145

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Myrtle

EBERSOLE

2. Date of Death

Month

Day

Year

February 6 1997

3. Time of Death

12:57 PM

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

5. Social Security Number

424 -32-2324

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Sept 17, 1930

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10e. State

MD

10b. County

Prince George

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1702 Columbia Avenue

10f. Zip Code

20785-3939

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

Grade 11

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Robert Colley

18. Mother's Name (First, Middle, Maiden Surname)

Annie Snow Gay

19a. Informant's Name/Relationship (Type, Print)

Robert C. Ebersole

spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1702 Columbia Ave. Hyattsville, Maryland 20785

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Meadowridge Memorial Pk

Date

2/10/97

20c. Location - City or Town, State

Dorsey, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donaldson Funeral Home, P.A.

313 Talbott Ave. Laurel, Maryland 20707-4389

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Renal Failure

Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3-4 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sepsis; Hypertension; Seizure disorder; Decubiti ulcer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Villanor S. Reyes MD

29c. License number

D29671

29d. Date signed (Month, Day, Year)

Feb. 6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Villanor S. Reyes MD 6501 LANDOVER RD CROFTON MD 21114

31. Date filed (Month, Day, Year)

FEB 10 1997

32. Registrar's Signature

Johnathan R. Riddell

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06146

|  |  |                     |   |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
|--|--|---------------------|---|--|--|--|---|---|--|--|---|----|---------------------|----------------------------------|--|----|------------------|----------------------------------|----|--|----------------------------------|----|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>WARREN L. EDWARDS</b>   |                     |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>14</b> Year <b>1997</b>   |  |   |   | 3. Time of Death<br><b>1:30 PM</b>   |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>McCreedy Memorial Hospital</b>  |                     |   |  | 4b. City, Town, or Location of Death<br><b>Crisfield</b>   |  |   |   | 4c. County of Death<br><b>Somerset</b>   |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-05-4797</b>  |                     | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 5, 1921</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
|  | Usual Residence of Decedent  |                     |   |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>  |                     | 10b. County<br><b>Somerset</b>  |  | 10c. City, Town or Location<br><b>Crisfield</b>  |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
|  | 10e. Street and Number<br><b>26406 E. Pear St.</b>   |                     |   |  | 10f. Zip Code<br><b>21817</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                 |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |                     | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>World War II</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>- - -</b>   |                     |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales Manager</b>  |  |   | 16b. Kind of Business/Industry<br><b>Jewelers</b>                       |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Warren Edwards</b>   |                     |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillian Shifflett</b>  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Isabelle C. Edwards (wife)</b>  |                     |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>26406 E. Pear St. - Crisfield, MD 21817</b>  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                     | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Salisbury Crematory</b>  |  | Date<br><b>2/17/97</b>   |  | 20c. Location - City or Town, State<br><b>Salisbury, MD</b> |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Robert H. Bradshaw</b>   |                     |   |  | 22. Name and Address of Facility<br><b>Bradshaw &amp; Sons Funeral Home</b><br><b>306 W. Main St. - Crisfield, MD 21817</b>  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |                     |   |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
|  | <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Sepsis Shock</b></td> <td>Due to (or as a consequence of):</td> <td rowspan="4">           Approximate Interval Between Onset and Death         </td> </tr> <tr> <td>b.</td> <td><b>Pneumonia</b></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> </table> |                     |   |  |  |  |   |   |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | <b>Sepsis Shock</b> | Due to (or as a consequence of): | Approximate Interval Between Onset and Death | b. | <b>Pneumonia</b> | Due to (or as a consequence of): | c. |  | Due to (or as a consequence of): | d. |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  | a.   | <b>Sepsis Shock</b> | Due to (or as a consequence of):  | Approximate Interval Between Onset and Death |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
|  | b.   | <b>Pneumonia</b>    | Due to (or as a consequence of):  |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
|  | c.   |                     | Due to (or as a consequence of):  |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
|  | d.   |                     | Due to (or as a consequence of):  |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                     |   |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |                     |   |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                     |   |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |                     |   |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                     |   |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |                     |   |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |                     |   |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
| 28a. Date of Injury (Month, Day Year)  |  |                     |   |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
| 28b. Time of Injury<br><b>M</b>  |  |                     |   |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |                     |   |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
| 28d. Describe how injury occurred  |  |                     |   |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |                     |   |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |                     |   |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                     |   |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
| 29b. Signature and title of certifier<br><b>Vijay Karumbunathan</b>  |  |                     |   |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
| 29c. License number<br><b>D48098</b>   |  |                     |   |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
| 29d. Date signed (Month, Day, Year)<br><b>2/14/97</b>  |  |                     |   |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, MD 21817</b>  |  |                     |   |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 18 1997</b>  |  |                     |   |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |
| 32. Registrar's Signature<br><b>Jubia...</b>   |  |                     |   |  |  |  |   |   |  |  |   |    |                     |                                  |  |    |                  |                                  |    |  |                                  |    |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06147

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EMMETT LEE FITZGERALD

2. Date of Death  
Month Day Year

2

13

97

3. Time of Death

1:00AM

4a. Facility Name (If not institution, give street and number)

Atlantic General Hospital

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral  
Director

5. Social Security Number

233-64-2192

6. Sex

XXM 2□ F

7. Age (In yrs. last birthday)

56

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

2/3/41

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Whaleyville

10d. Inside City Limits

1□ Yes 2□ No

10e. Street and Number

8135 Shavox Church RD

10f. Zip Code

21872

10g. Citizen of What Country?

USA

11. Marital Status

1□ Never Married 2□ Married

3□ Widowed 4□ Divorced

12. Was Decedent Ever in U.S.

1□ Yes 2□ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2□ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Courier

16b. Kind of Business/Industry

Banking

17. Father's Name (First, Middle, Last)

Robert Fitzgerald

18. Mother's Name (First, Middle, Maiden Surname)

Lamax Irene Evans

19a. Informant's Name/Relationship (Type, Print)

Jay M. Fitzgerald

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PO Box 53 Whaleyville, MD 21872

20a. Method of Disposition

1□ Burial 2□ Cremation 3□ Removal from State

4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cape Henlopen Crematory 2/15/97 Frankford, DE

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burbage Funeral Home

108 Williams St. Berlin, MD 21811

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

Acute Pulm. Edema

Due to (or as a consequence of):

b.

Myocardial Infarction

Due to (or as a consequence of):

c.

Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Non-Insulin Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2□ No 3□ Probably 4□ Unknown

24a. Was an autopsy performed?

1□ Yes 2□ No

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2□ No

25. Was case referred to medical examiner?  
1□ Yes 2□ No

26. Place of Death (Check only one)

Hospital: 1□ Inpatient 2□ ER/Outpatient 3□ DOA

Other: 4□ Nursing Home 5□ Residence 6□ Other (Specify)

27. Manner of Death

1□ Natural

2□ Accident

3□ Suicide

4□ Homicide

5□ Pending Investigation

6□ Could not be determined

28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1□ Yes 2□ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)

1□ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROY CRAGWAY JR MD

9733 HEATHWAY DRIVE

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

John Anderson-Robert

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06148

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Cecelia Joan Flint

2. Date of Death

FEB 12 1997

3. Time of Death

5:00AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

GARRETT COUNTY MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

OAKLAND

4c. County of Death

GARRETT

5. Social Security Number

212-76-8546

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOV 27 1949

9. Birthplace (State or Foreign Country)

BALTIMORE, MD

Usual Residence of Decedent

10a. State

MD

10b. County

GARRETT

10c. City, Town or Location

OAKLAND

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

360 W LIBERTY ST.

10f. Zip Code

21530

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

None

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

None

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

THOMAS B FLINT

18. Mother's Name (First, Middle, Maiden Surname)

JOSEPHINE HOUGHENS

19a. Informant's Name/Relationship (Type, Print)

CHERYL LOCKHART

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

360 W LIBERTY ST, OAKLAND, MD 21550

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BETHEL CHURCH

Date

20c. Location - City or Town, State

CASCADE, MD.

21. Signature of Funeral Service Licensee

James A. Boulenger

22. Name and Address of Facility GROVE FUNERAL HOME, INC  
505 BROAD ST WAYNESBORO PA 17268

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. BRAIN DEATH

Due to (or as a consequence of):

48 HR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ANOXIA

Due to (or as a consequence of):

49 HR

c. CARDIAC ARREST

Due to (or as a consequence of):

49 HR

d. UNKNOWN

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicidal 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

2-9-97

28b. Time of Injury

1900 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James A. Boulenger

29c. License number

D47309

29d. Date signed (Month, Day, Year)

2-12-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3110. FOURTH ST. OAKLAND, MARYLAND 21550

31. Date filed (Month, Day, Year)

FEB 20 1997

32. Registrar's Signature

John Shuster-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06149

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Esther Andujar Ford

2. Date of Death

February 17, 1997

3. Time of Death

8:30 PM

4a. Facility Name (If not institution, give street and number)

Reeders Memorial Home

4b. City, Town, or Location of Death

Boonsboro

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

253-68-3967

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 11 1925

9. Birthplace (State or Foreign Country)

Puerto Rico

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

42 East Avenue

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Puerto Rican

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Military Mess Hall

17. Father's Name (First, Middle, Last)

Juan Andujar

18. Mother's Name (First, Middle, Maiden Surname)

Eulalia Sanlaueella

19a. Informant's Name/Relationship (Type, Print)

Nilza Young/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11311 Grouse Road Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Hagerstown Crematory

Date

2-20-97

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Minnich Funeral Home

415 E. Wilson Blvd. Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Myocardial infarction  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

2 Hrs

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b.

Renal Failure  
Due to (or as a consequence of):

10 yrs

c.

Diabetes mellitus  
Due to (or as a consequence of):

15 yrs

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of causa  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D44996

29d. Date signed (Month, Day, Year)

Feb 18, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Zafar Malik 20311 Lappans Road, Boonsboro, Maryland 21713/301-432-8470

31. Date filed (Month, Day, Year)

FEB 21 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06150

## Certificate of Death

Reg. No.

|  |   |  |   |   |  |   |   |  |  |  |
|--|---|--|---|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>RICHARD NMN GIBSON  |  |   |   |  |   | 2. Date of Death<br>Month Day Year<br>Feb 15, 1997  |  | 3. Time of Death<br>4:00 P.M.  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Washington County Hospital  |  |   |   |  |   | 4b. City, Town, or Location of Death<br>Hagerstown  |  | 4c. County of Death<br>Washington  |  |
| Funeral<br>Director  | 5. Social Security Number<br>570-18-2941  |  | 8. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>79 Yrs.  |   | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.   |  |
|  | 6. Date of Birth<br>Month Day Year<br>July 16, 1917   |  | 9. Birthplace (State or Foreign Country)<br>Washington D.C.   |   |  |   |   |  |  |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |  |   |   |  |   |   |  |  |  |
|  | 10a. State<br>MD  |  | 10b. County<br>Washington   |   | 10c. City, Town or Location<br>Boonsboro   |   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br>8150 Mountain Laurel Road   |  |   |   | 10f. Zip Code<br>21713   |   | 10g. Citizen of What Country?<br>USA  |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WWII<br>If Yes, Give Year or Dates: Korean |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br>8  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Hospital Administrator  |   |   | 16b. Kind of Business/Industry<br>Federal Government             |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>John W. Gibson   |  |   |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary E. Cummins  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Dorothy F. Gibson, Wife   |  |   |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8150 Mountain Laurel Road, Boonsboro, Maryland 21713 |  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Smithsburg, Crematory |  | Date<br>Feb. 20   |   | 20c. Location - City or Town, State<br>Smithsburg, Maryland      |  |  |
|  | 21. Signature of Funeral Service Licensee<br>Kelley A. Yunker   |  |   |   |  |   | 22. Name and Address of Facility<br>Douglas A. Fiery Funeral Home<br>1331 Eastern Blvd. N., Hagerstown, Maryland 21742                                |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Pneumonia<br>Due to (or as a consequence of):<br>b. Non-Hodgkins Lymphoma<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>3 weeks<br>6 months |  |   |   |  |   |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Cerebrovascular Accident<br>Coronary Artery Disease<br>Dehydration   |   |  |   |   |  |   |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |  |   |   |  |   |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |   |  |   |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   |   |  |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |   |  |   |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |   |   |  |   |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)                        |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred                                |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br>Pamela Fox Bradford |   | 29c. License number<br>D38892   |  | 29d. Date signed (Month, Day, Year)<br>2-15-97  |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Pamela Fox Bradford m.d. 11110 Medical Campus Rd. Hag. Md  |   |  |   |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 18 1997   |   |  |   |   |  |   |   |  |  |  |
| 32. Registrar's Signature<br>Julia Anderson  |   |  |   |   |  |   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



97 06151

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Margaret Virginia Guessford</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH <i>February</i> DAY <i>18</i> , YEAR <i>1997</i>  |  | 3. TIME OF DEATH<br><i>11:30 A.M.</i>   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>214-28-0549</i>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>65</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>Oct. 10, 1931</i>                                  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>11335 Youngstown Dr. Apt. 2102</i>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Hagerstown</i>  |  | 9c. COUNTY OF DEATH<br><i>Washington</i>  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br><i>Md.</i>  |  | 10b. COUNTY<br><i>Washington</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Hagerstown</i>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>11335 Youngstown Dr. Apt. 2102</i>   |  |  |  | 10f. ZIP CODE<br><i>21742</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Aid</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Nursing Home</i>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Clifford G. Himes Sr.</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Mary G. Kindle</i>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Jeffrey L. Harbaugh</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>11335 Youngstown Dr. Apt. 2102 Hagerstown, Md. 21742</i>                                    |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Smithsburg Cemetery Feb. 22, 97</i>  |  | 20c. LOCATION — City or Town, State<br><i>Smithsburg, Md.</i>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James P. Davis</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783</i>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  | a. <i>lung cancer</i><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  | b. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|   |  | c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|   |  | d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>chronic lymphocytic leukemia</i>   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER<br>(Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Hind Hamdan MD</i>   |  | 29c. LICENSE NUMBER<br><i>D46473</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>Feb. 19, 1997</i>                                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Hind Hamdan, M.D.; 363 S. Cleveland Ave; Hagerstown, MD 21740.</i>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>FEB 20 1997</i>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew Rodell</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68766

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



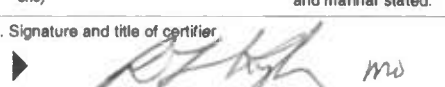
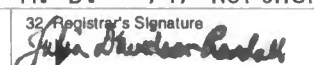
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06152

|  |   |                                       |   |   |  |  |  |  |   |
|--|---|---------------------------------------|---|---|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Hilda Lucille Grim  |                                       |   |   | 2. Date of Death<br>Month Day Year<br>Feb. 18, 1997  |  | 3. Time of Death<br>11:25 AM                                     |  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br>2402 Dargan Road  |                                       |   |   | 4b. City, Town, or Location of Death<br>Sharpsburg   |  | 4c. County of Death<br>Washington                                |  |   |
| Funeral<br>Director  | 5. Social Security Number<br>213-24-8651  |                                       | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>67 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>May 23, 1929              |  |   |
|  | 9. Birthplace (State or Foreign Country)<br>Maryland  |                                       |   |   |  |  |  |  |   |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |                                       |   |   |  |  |  |  |   |
|  | 10a. State<br>Maryland  |                                       | 10b. County<br>Washington   |   | 10c. City, Town or Location<br>Sharpsburg  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |
|  | 10e. Street and Number<br>2402 Dargan Road  |                                       |   |   | 10f. Zip Code<br>21782   |  | 10g. Citizen of What Country?<br>USA                             |  |   |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 9 College (1-4 or 5+)  |                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Housewife                                |   | 16b. Kind of Business/Industry<br>Homemaker  |  |  |  |   |
|  | 17. Father's Name (First, Middle, Last)<br>Chester Myers  |                                       |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Nellie Mae Gray   |  |  |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Lloyd D. Grim - Husband   |                                       |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2402 Dargan Road - Sharpsburg, MD 21782   |  |  |  |   |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Samples Manor Cemetery  |   | Date<br>2/21/97  |  | 20c. Location - City or Town, State<br>Sharpsburg, MD            |  |   |
|  | 21. Signature of Funeral Service Licensee<br>   |                                       |   |   | 22. Name and Address of Facility<br>Eackles-Spencer Funeral Home<br>Harpers Ferry, WV 25425  |  |  |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Emphysema</u><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                       |   |   |  |  |  |  | Approximate Interval Between Onset and Death<br>10 yrs. |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Rheumatoid Arthritis</u><br><u>Hypercholesterolemia</u>   |   |                                       |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                                       |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                                       |   | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year) |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |                                       |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |                                       |   |   |  |  |  |  |   |
| 29b. Signature and title of certifier<br> MD  |   |                                       |   | 29c. License number<br>D 26579  |  | 29d. Date signed (Month, Day, Year)<br>Feb. 19, 1997                                 |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>R. Lawrence Kugler, M. D. - 747 Northern Avenue - Hagerstown, MD 21742   |   |                                       |   |   |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br>FEB 19 1997   |   |                                       |   | 32. Registrar's Signature<br>  |  |  |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06153

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Cecil Phillip Gough

2. Date of Death

February 15 1997

3. Time of Death

23:35

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

218-16-1497

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth (Month, Day, Year)

Apr 19, 1925

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Cecil

10c. City, Town or Location

Rising Sun

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

115 Westwood Rd.

10f. Zip Code

21911

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (13-16)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Reproduction &amp; Field Printing

16b. Kind of Business/Industry

Aberdeen Proving Grounds

17. Father's Name (First, Middle, Last)

Cecil P. Gough, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Ida G. Fogus

19a. Informant's Name/Relationship (Type, Print)

Sara W. Gough/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

115 Westwood Rd Rising Sun MD 21911

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

West Nottingham Cmty Feb 19 1997

Date

20c. Location - City or Town, State

Coloma MD

21. Signature of Funeral Service Licensee

*Richard L. Gough*

22. Name and Address of Facility

R. T. Foard Funeral Home, P.A.  
111 S Queen St. Rising Sun MD 21911

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

End stage chronic obstructive pulmonary disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

History of coronary artery disease  
Hypertension  
Recent prostate hypertrophy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Richard L. Gough MD*

29c. License number

D46412

29d. Date signed (Month, Day, Year)

2/16/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rising Sun 21911 S. Union Ave

Havre de Grace MD 21078

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

*Julia Davidson-Randall*State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06154

Reg. No.

|   |  |   |  |  |   |  |   |   |
|---|--|---|--|--|---|--|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>John Griffin</b>  |   |  |  | 2. Date of Death<br>Month <b>February</b> Day <b>3</b> Year <b>1997</b> |  | 3. Time of Death<br><b>11:2 AM</b>                        |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Prince George's Hospital Center</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b>                 |  | 4c. County of Death<br><b>Prince George</b>               |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>253-52-2587</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>May 5, 1934</b> | 9. Birthplace (State or Foreign Country)<br><b>Georgia</b>  |
|   | Usual Residence of Decedent  |   |  |  |   |  |   |   |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Prince George</b>   |  | 10c. City, Town or Location<br><b>Capitol Heights</b>  |   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
| 10e. Street and Number<br><b>407 Eastern Ave. Apt A</b>   |  |   |  | 10f. Zip Code<br><b>20743</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Printer Operator</b>   |   | 16b. Kind of Business/Industry<br><b>Printing Company</b>  |   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Will Griffin</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eliza Whitehead</b>  |   |  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Beverly Ann Griffin Dugger daughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3155 Bath Patterson Rd. Hephzibih, Georgia 30815</b>                                     |   |  |   |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Thankful Cemetery</b>  |  | Date<br><b>2/9/97</b>  |   | 20c. Location - City or Town, State<br><b>Blythe, Georgia</b>  |   |   |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Donaldson Funeral Home, P.A.<br/>313 Talbott Ave. Laurel, Maryland 20707-4389</b>   |   |  |   |   |
| 23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. <b>Ventricular tachycardia</b><br>Due to (or as a consequence of):<br>b. <b>Cardiogenic Shock</b><br>Due to (or as a consequence of):<br>c. <b>Myocardial Infarction</b><br>Due to (or as a consequence of):<br>d. <b>Coronary artery disease, Atherosclerotic heart disease</b> |  |   |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>1 hr</b><br><b>12 hr</b><br><b>1-2 days</b><br><b>7 yr</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |
|   |  |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |
|   |  |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   | 28d. Describe how Injury occurred   |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |  |   |   |
|   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |   |  |   |   |
| 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>033483</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>2/4/97</b>   |   |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>PRADEEP P. SRIVASTAVA, MD. 7227-B Hemlock Pkwy, Greenbelt, MD 20770</b>  |  |   |  |  |   |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 10 1997</b>   |  | 32. Registrar's Signature<br>  |  |  |   |  |   |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

5

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06155

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rectina T. Gludt

2. Date of Death

February 13 1997

3. Time of Death

7:05 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

11887 New Country Lane

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

471-40-3590

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug 20, 1911

9. Birthplace (State or Foreign Country)

Minnesota

Usual Residence of Decedent

10a. State

Minnesota

10b. County

Wabasha

10c. City, Town or Location

Lake City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

707 North Garden Street

10f. Zip Code

55041

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Public Schools

17. Father's Name (First, Middle, Last)

Ervin Terwilliger

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Roberts

19a. Informant's Name/Relationship (Type, Print)

Mary J. Gludt/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11887 New Country Lane Columbia, Maryland 21044

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakewood Cemetery

Date

2-17-97

20c. Location - City or Town, State

Lake City, MN

21. Signature of Funeral Service Licensee

Harry H. Witzke

22. Name and Address of Facility

Harry H. Witzke Funeral Home, Inc.

4112 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Malignant Arteriosclerosis

Due to (or as a consequence of):

Approximate interval between Onset and Death

Sudden

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMERS DISEASE

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John I. Levine, MD

29c. License number

022856

29d. Date signed (Month, Day, Year)

February 13, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John I. Levine, MD, 11055 Little Patuxent Pkwy, Columbia, MD 21044

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

John I. Levine, MD

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06156

Reg. No.

|  |   |  |   |                                |  |
|--|---|--|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>EDNA PHYLLIS  |  | 2. Date of Death<br>Month: FEBRUARY Day: 13 Year: 1997  |                                | 3. Time of Death<br>0500   |
|  | 4a. Facility Name (If not institution, give street and number)<br>PENINSULA REGIONAL MEDICAL CENTER   |  | 4b. City, Town, or Location of Death<br>SALISBURY   |                                | 4c. County of Death<br>WICOMICO  |
| Funeral<br>Director  | 5. Social Security Number<br>180-16-1066  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>75 Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br>August 7, 1921   |  | 9. Birthplace (State or Foreign Country)<br>Maryland  |                                |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |  |   |                                |  |
|  | 10e. State<br>Maryland  | 10b. County<br>Wicomico  | 10c. City, Town or Location<br>Salisbury  |                                | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br>1403 Allenwood Drive  |  | 10f. Zip Code<br>21801  |                                | 10g. Citizen of What Country?<br>USA   |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 6   |                                |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Teacher  |  | 16b. Kind of Business/Industry<br>Public Schools  |                                |  |
|  | 17. Father's Name (First, Middle, Last)<br>Nelson Cade  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Roberts   |                                |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Werner L. Gruber Jr./husband  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1403 Allenwood Dr., Salisbury, MD 21801  |                                |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Springhill Memory Gardens   |                                | 20c. Location - City or Town, State<br>Hebron, MD  |
|  | 21. Signature of Funeral Service Licensee<br>David H. Thompson MO1051   |  | 22. Name and Address of Facility<br>Holloway Funeral Home<br>501 Snow Hill Rd., Salisbury, MD 21804   |                                |  |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |                                | Approximate Interval Between Onset and Death   |
|  | a. Cardiorespiratory failure  |  |   |                                |  |
|  | b. metastatic cancer  |  |   |                                |  |
|  | c. pathologic tumor   |  |   |                                |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|  |   |  |   |                                | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
|  |   |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|  |   |  |   |                                |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once. | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |                                | 28b. Time of Injury<br>M   |
|  |   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |                                | 28d. Describe how injury occurred  |
|  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |
| State<br>Registrar   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.           |  |   |                                |  |
|  | 29b. Signature and title of certifier<br>Thomas Brannon MD  |  | 29c. License number<br>38103  |                                | 29d. Date signed (Month, Day, Year)<br>2/13/97   |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>THOMAS BRANNON, M.D. 111 ANNIS ST. SALISBURY, MD 21801  |  |   |                                |  |
|  | 31. Date filed (Month, Day, Year)<br>FEB 14 1997  |  | 32. Registrar's Signature<br>John Davidson-Randall  |                                |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06157

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PHYLLIS ULLMAN GIORDANO

2. Date of Death

February 10, 1997

3. Time of Death

6:15 PM

4a. Facility Name (If not Institution, give street and number)

3516 Milton Mill Rd.

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

Funeral  
Director

5. Social Security Number

125-03-3995

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

October 17, 1919

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

3516 Milton Mill Rd.

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Stock Transfer

16b. Kind of Business/Industry

Auto Industry

17. Father's Name (First, Middle, Last)

Benjamin

Ullman

18. Mother's Name (First, Middle, Maiden Surname)

Marie

Raynsford

19a. Informant's Name/Relationship (Type, Print)

Frank Giordano/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3516 Milton Mill Rd., Salisbury, MD 21804

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Springhill Memory Gardens

Date

2/13/97

20c. Location - City or Town, State

Hebron, MD

21. Signature of Funeral Service Licensee

MOIOSI

22. Name and Address of Facility

Holloway Funeral Home

501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dementia

Due to (or as a consequence of):

b. Parkinson's Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D25674

29d. Date signed (Month, Day, Year)

2/12/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JA Cockery, MD 100 Down St. Salisbury, MD 21804

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

Julia Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06158

Reg. No.

|   |   |   |   |  |  |   |  |   |  |
|---|---|---|---|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JESSIE J. HINER</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 14 1997</b>  |   | 3. Time of Death<br><b>6:10 PM.</b>  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>BERLIN NURSING &amp; REHAB. CTR.</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>BERLIN</b>  |   | 4c. County of Death<br><b>WORCESTER</b>  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>235-26-5619</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>6-3-13</b>   | 9. Birthplace (State or Foreign Country)<br><b>W. VA.</b> |  |
|   | Usual Residence of Decedent   |   |   |  |  |   |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD.</b>  |   | 10b. County<br><b>WORCESTER</b>   |  | 10c. City, Town or Location<br><b>BERLIN</b>   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br><b>59 BATTERSEA LA.</b>   |   |   |  | 10f. Zip Code<br><b>21811</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                            |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>College (1-4or 5+)</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ADMINISTRATIVE ASST.</b>              |  | 16b. Kind of Business/Industry<br><b>US GOVERNMENT</b>   |   |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 17. Father's Name (First, Middle, Last)<br><b>TATE H. HINER</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ROBERTA GUM</b>  |   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>JOHN T. HINER</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>916 OCEAN PINES BERLIN, MD., 21811</b>   |   |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>OAK GROVE CEMETERY</b>   |  | 20c. Location - City or Town, State<br><b>2-19 HILLSBORO, W.VA.</b>  |   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>                                    |   |  |
|   | 22. Name and Address of Facility<br><b>ULLRICH FUNERAL HOME BERLIN, MD., 21811</b>  |   |   |  | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Arteriosclerotic Heart Disease 10 yrs.</b><br>Due to (or as a consequence of):<br><b>b. Generalized Atherosclerosis 10 yrs</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Obstructive Pulmonary Disease</b><br><b>Chronic Brain Syndrome</b>   |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |   |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred                         |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>[Signature]</i>   |   | 29c. License number<br><b>D29505</b>             |  | 29d. Date signed (Month, Day, Year)<br><b>2-15-97</b>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GREGORIO M. BELLOSO, M.D. 5302 CHINABERRY DRIVE, SALISBURY, MD 21801</b>   |   |   |   |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 18 1997</b>   |   | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |   |  |   |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06159

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD F. HARBESON

2. Date of Death

FEBRUARY 13, 1997

3. Time of Death

0620

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Atlantic GENERAL HOSPITAL

4b. City, Town, or Location of Death

BERLIN

4c. County of Death

WORCESTER

5. Social Security Number

218-28-0990

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

3-27-32

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

WORCESTER

10c. City, Town or Location

BERLIN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11003 GRAYS CORNER RD.

10f. Zip Code

21811

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TOOL GRINDER

16b. Kind of Business/Industry

SHARPENING

17. Father's Name (First, Middle, Last)

CLIFFORD HARBESON

18. Mother's Name (First, Middle, Maiden Surname)

NAOMI MCGREEVY

19a. Informant's Name/Relationship (Type, Print)

ANNA V. HARBESON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11003 GRAYS CORNER RD. BERLIN, MD., 21811

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SALISBURY CREMATORY

Date

2-15

20c. Location - City or Town, State

SALISBURY, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ULLRICH FUNERAL HOME BERLIN, MD., 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Chronic renal failure

Due to (or as a consequence of):

c. hypertension

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

00050605

29d. Date signed (Month, Day, Year)

Feb 13 97.

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

DR JOHN CHRISTIE

4733 Heathway Dr, Berlin, Md 21811

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 900-686-0000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06160

|   |  |  |  |  |   |  |   |  |
|---|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>STERLING RUSSELL HARE, SR.</b>  |  |  |  | 2. Date of Death<br>Month <b>FEB</b> Day <b>13</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>4:00 PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>15308 OLD HANOVER ROAD</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>UPPERCO</b>  |  | 4c. County of Death<br><b>BALTIMORE</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>217-18-8610</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>SEP 13, 1920</b>                                  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>UPPERCO</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>15308 OLD HANOVER ROAD</b>  |  | 10f. Zip Code<br><b>21155</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MAINTENANCE ENGINEER</b>                       |  | 16b. Kind of Business/Industry<br><b>CATHOLIC ARCHDIOCESE</b>   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>LAWRENCE T. HARE</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>VERGIE VIOLA ARMACOST</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>KATHERINE M. HARE</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>15308 OLD HANOVER RD, UPPERCO, MD 21155</b>   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ST PAULS CEMETERY</b>   |  | 20c. Location - City or Town, State<br><b>ARCADIA, MD</b>   |  | 20d. Date<br><b>2/17</b>  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br><b>ELINE FUNERAL HOME<br/>934 S MAIN ST, HAMPSTEAD, MD 21074</b>  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. atherosclerotic coronary vascular disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. {</b><br><b>c. {</b><br><b>d. {</b> |  |  |  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Aortic Stenosis, Mitral Regurg.</b>   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |
|   |  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
| To Be Completed by Physician/Medical Examiner |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |  |   |  |   |  |
|   | 29b. Signature and title of certifier<br><br><b>NICK MELLIS MD</b>  |  |  |  | 29c. License number<br><b>D47762</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/14/97</b>                                       |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>DR NICK MELLIS, 7801 YORK RD, SUITE TOWSON, MD</b>  |  |  |  |   |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br><b>FEB 18 1997</b>  |  |  |  | 32. Registrar's Signature<br>  |  |   |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06161

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary F. Harman

2. Date of Death  
Month Day Year

2

17

97

0340

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Carroll County General Hospital

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

212-28-3773

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

NOV 23, 1906

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CARROLL

10c. City, Town or Location

HAMPSTEAD

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1112 MAIN STREET

10f. Zip Code

21074

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

CHARLES MCMILLAN

18. Mother's Name (First, Middle, Maiden Summa)

GEORGE ANNA TAYLOR

19a. Informant's Name/Relationship (Type, Print)

WAYNE HARMAN, SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

703 HILLEN ROAD, TOWSON, MD 21286

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

HAMPSTEAD CEMETERY

Date

2/19

20c. Location - City or Town, State

HAMPSTEAD, MD

21. Signature of Funeral Service Licensee

Eline W. Elmer

22. Name and Address of Facility

ELINE FUNERAL HOME

934 S MAIN ST, HAMPSTEAD, MD 21074

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.UNKNOWN perforated hollow  
viscusApproximate  
Interval Between  
Onset and Death

12 hrs

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Doree L. Elmer MD

29c. License number

D23719

29d. Date signed (Month, Day, Year)

2/17/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Doree L. Elmer 295 Stone Ave Westminster, Md 21157

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

John A. Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06162

|                                     |  |  |   |                                |  |
|-------------------------------------|--|--|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>LEONARD JOSEPH HOUSEHOLDER</b>  |  | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 16, 1997</b>  |                                | 3. Time of Death<br><b>1540PM</b>  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>14014 MARSH PIKE-AVALON MANOR</b>   |  | 4b. City, Town, or Location of Death<br><b>HAGERSTOWN</b>   |                                | 4c. County of Death<br><b>WASHINGTON</b>   |
| Funeral<br>Director                 | 5. Social Security Number<br><b>215-18-1973</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|                                     | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 2, 1916</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |                                |  |
| To Be Completed by Funeral Director | 10e. State<br><b>Maryland</b>  |  | 10b. County<br><b>Washington</b>  |                                | 10c. City, Town or Location<br><b>Sharpsburg</b>   |
|                                     | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                |  |
|                                     | 10e. Street and Number<br><b>7202 Dam #4 Road</b>  |  | 10f. Zip Code<br><b>21782</b>   |                                | 10g. Citizen of What Country?<br><b>USA</b>  |
|                                     | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |
|                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |                                |  |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Farmer</b>  |                                | 16b. Kind of Business/Industry<br><b>Agriculture</b>   |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>Clifford Joseph Householder</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edith Susan Knable</b>  |                                |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert R. Householder (Son)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>22025 Leitersburg-Smithsburg Road Smithsburg, MD. 21783</b>   |                                |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greenlawn Memorial Park</b>  |                                | 20c. Location - City or Town, State<br><b>Williamsport, MD.</b>  |
|                                     | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>P.O. Box 348<br/>Osborne Funeral Home Williamsport, MD. 21795</b>  |                                |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>a. Calcific Aortic Stenosis AND Atherosclerotic</b><br>Due to (or as a consequence of):<br><b>b. Coronary Artery Disease</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |                                | Approximate Interval Between Onset and Death   |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|                                     | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|                                     | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)<br><b>M</b>   |                                | 28b. Time of Injury<br><b>M</b>  |
|                                     | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred   |                                |  |
|                                     | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |
|                                     | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                       |  |   |                                |  |
|                                     | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>O.C.M.E.</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 17, 1997</b>  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Marysanto P. Wilson MD 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |                                |  |
| State Registrar                     | 31. Date filed (Month, Day, Year)<br><b>FEB 18 1997</b>  |  | 32. Registrar's Signature<br>   |                                |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06163

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MAR/ ANN HICKMAN

2. Date of Death

FEBRUARY 15 1997

3. Time of Death

0715

4a. Facility Name (If not institution, give street and number)

UNION HOSPITAL

4b. City, Town, or Location of Death

ELKTON

4c. County of Death

CECIL

Funeral  
Director

5. Social Security Number

192-34-2271

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

51

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MAY 25 1945

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10a. State

MD.

10b. County

CECIL

10c. City, Town or Location

ELKTON/CHARLESTOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

104 CAROLINE ST.

10f. Zip Code

21914

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MAIL ROOM CECIL COM. COLLEGE

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Joseph Ricker

18. Mother's Name (First, Middle, Maiden Surname)

GLADYS SLOWACKER

19a. Informant's Name/Relationship (Type, Print)

WALTER HAWKINS - Boyfriend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

803 CONCORD ST. HAWKESDALE MD. 21078

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

RA Ferns Crematory

Date

2/1/97

20c. Location - City or Town, State

Westchester PA

21. Signature of Funeral Service Licensor

[Signature]

22. Name and Address of Facility

Gee Funeral Home 259 E. MAIN ST. ELKTON MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Small cell carcinoma Lung

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

C I M

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Metastatic to Liver (#1)

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jui chih Hsu MD

29c. License number

D04823

29d. Date signed (Month, Day, Year)

2/16/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jui chih Hsu, MD. 223 West main st. Elkton MD.

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06164

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Madeline Teresa Holman

2. Date of Death

February 12, 1997

3. Time of Death

2:30 am

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

11213 A Avalanche Way

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

196-14-7136

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 22, 1922

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10e. State

Maryland

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11213 A Avalanche Way

10f. Zip Code

21044

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

Grade 12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Cafeteria Worker

16b. Kind of Business/Industry

Prince Georges County

Board of Education

17. Father's Name (First, Middle, Last)

Frank Kirk

18. Mother's Name (First, Middle, Maiden Surname)

Lucinda Davis

19a. Informant's Name/Relationship (Type, Print)

Ann Elizabeth Holman / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11213 A Avalanche Way Columbia, Maryland 21044

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Mem. Park

Date

Feb 14 1997

20c. Location - City or Town, State

Dorsey, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donaldson Funeral Home, P.A.

313 Talbott Avenue Laurel, Maryland 20707

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. lung cancer, metastatic to brain

2 mos

Due to (or as a consequence of):

b. emphysema

20 yrs

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 33836

29d. Date signed (Month, Day, Year)

2/13/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marc E. Boisvert 7350 Van Dusen Rd #450 Laurel, MD 20707

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

15



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06165

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Virginia

Harris

2. Date of Death

February 11, 1997

3. Time of Death

11:10 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Salisbury Center: Genesis Eldercare

4b. City, Town, or Location of Death

Salisbury, MD

4c. County of Death

Wicomico

5. Social Security Number

220-10-8299

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 31 1914

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Fruitland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

Poplar Street Apt. 101

10f. Zip Code

21826

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

George Levin Collins

18. Mother's Name (First, Middle, Maiden Surname)

Edith Jones

19a. Informant's Name/Relationship (Type, Print)

Margo Palmer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

528 A. Winder St. Salisbury, Md. 21801

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Calvary Church Cem.

Date

2/15

20c. Location - City or Town, State

Fruitland, Md.

21. Signature of Funeral Service Licensee

Gladys B. Stewart

22. Name and Address of Facility

Stewart Funeral Home  
821 West Rd. Salisbury, Md. 21801

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

b. Multiple Infarct Dementia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

240°

years 28

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hx MI

Hx THORACIC CANCER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gladys B. Stewart

29c. License number

D39813

29d. Date signed (Month, Day, Year)

2/12/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. K. W. S.

1104 Healthway Dr., Salisbury, MD 21804

31. Date filed (Month, Day, Year)

FEB 14 1997

Registrar's Signature

J. K. W. S.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

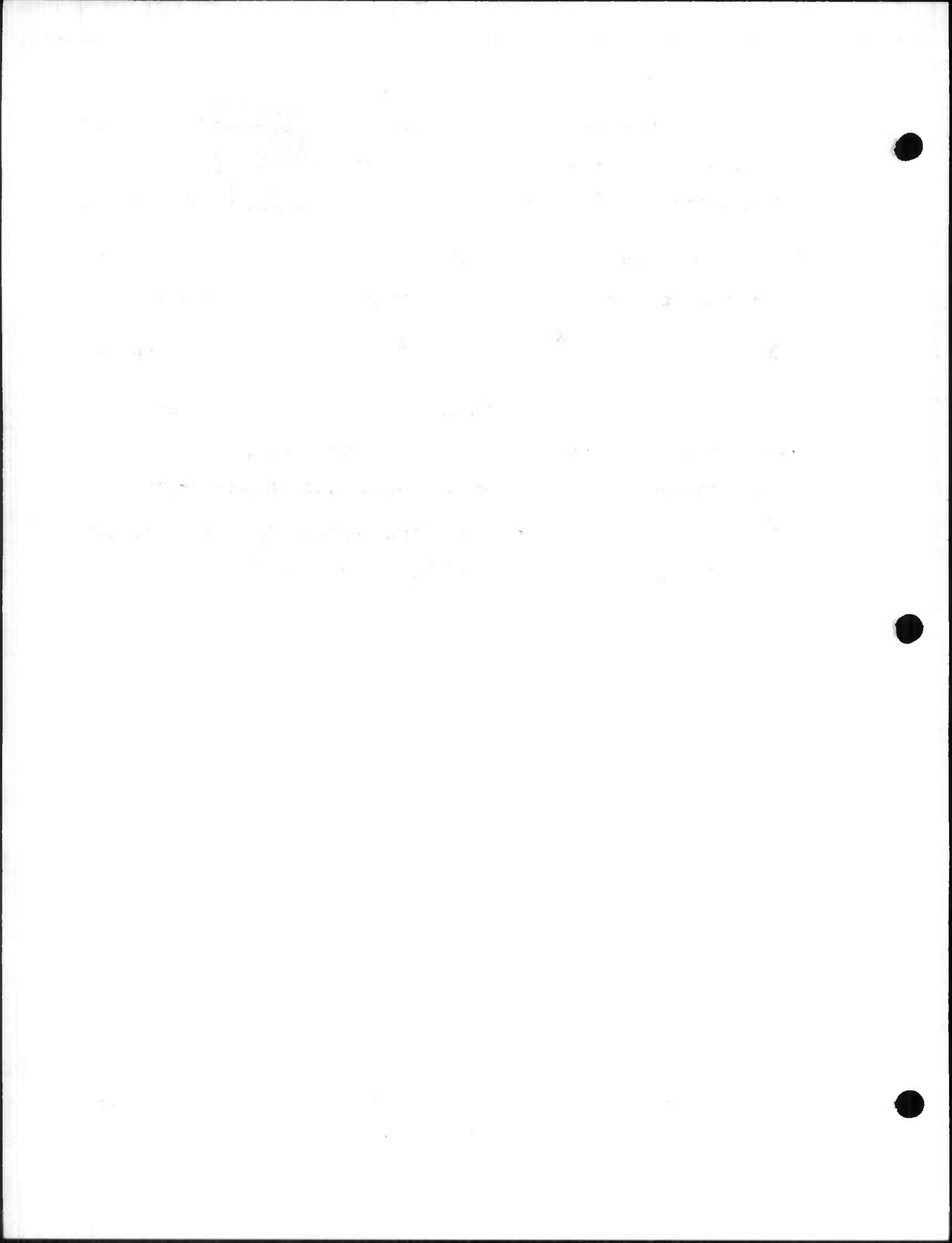
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06166

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mandy Lee

2. Date of Death  
Month Day Year  
HUNTLEY FEBRUARY 10, 19973. Time of Death  
0058

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

215-20-4261

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

March 12, 1925

9. Birthplace (State or Foreign  
Country)

GA

Usual Residence of Decedent

10a. State

MD

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits  
1 ☒ Yes 2 ☐ No

10e. Street and Number

404 E. Church St.

10f. Zip Code

21801

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
7th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Processor

16b. Kind of Business/Industry

Food

17. Father's Name (First, Middle, Last)

Andrew Jenkins

18. Mother's Name (First, Middle, Maiden Surname)

Virgie Belle Powell

19a. Informant's Name/Relationship (Type, Print)

Melody McCarthy

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

404 E. Church St., Salisbury, MD 21801

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Green Acres Memorial Park

Date

2/14/97

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lewis N. Watson Funeral Home  
1618 West Rd., Salisbury, MD 2180123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)Sudden Death, Suspected Recurrence  
of CVAApproximate  
Interval Between  
Onset and Death

1 hr med wt

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CVA (multiple) LFTN SID POC  
Arteriosclerosis Odontogenic infection  
osteomyelitis Evans Syndrome

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

M. G. MD

29c. License number

D39813

29d. Date signed (Month, Day, Year)

2/12/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MADKINS

1104 Westbury Drive, SALIS MD 21804

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

John Dawson-Radell

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 06167

|  |   |   |   |   |   |  |  |   |  |
|--|---|---|---|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Beulah Hoskin   |   |   |   | 2. Date of Death<br>Month Day Year<br>Feb 10 1997   |  | 3. Time of Death<br>2202   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Atlantic General Hospital   |   |   |   | 4b. City, Town, or Location of Death<br>Berlin  |  | 4c. County of Death<br>Worcester                                 |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>213-24-2275  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>67 Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>March 19, 1929            |   |  |
|  | Usual Residence of Decedent   |   | 9. Birthplace (State or Foreign Country)<br>MD  |   |   |  |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br>MD  | 10b. County<br>Worcester  | 10c. City, Town or Location<br>Berlin   |   |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |   |  |
|  | 10e. Street and Number<br>508 Bay St., Mallard Ridge Apt.   |   |   |   | 10f. Zip Code<br>21811  |  | 10g. Citizen of What Country?<br>U.S.                            |   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 9th College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Laborer                                  |   | 16b. Kind of Business/Industry<br>Auto  |  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br>Charles Pitts  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Emma Jarmon Pitts  |  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Emma Pitts  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10518 Flower St., Apt. 5, Berlin, MD 21811   |  |  |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St. Paul Cemetery   |   | Date<br>2/15/97   | 20c. Location - City or Town, State<br>Berlin, MD  |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |   |   |   | 22. Name and Address of Facility<br>Lewis N. Watson Funeral Home<br>1618 West Rd., Salisbury, MD 21801  |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. breast cancer<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |   |   |   |   |  |  |   | Approximate Interval Between Onset and Death<br>3 years  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |   |   |  |  |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M                  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  | 28d. Describe how injury occurred   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br>Robert F. Durkin<br>Physician  |   | 29c. License number<br>H44283             |   | 29d. Date signed (Month, Day, Year)<br>2/10/97   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Robert F. Durkin<br>9733 Hillman Road<br>Berlin, MD  |   |   |   |   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>FEB 13 1997   |   |   |   |   |   |  |  | 32. Registrar's Signature<br>   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06168

Reg. No.

|   |   |  |  |  |  |  |   |  |
|---|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>JOSEPH EARL KEY   |  |  |  | 2. Date of Death<br>Month Day Year<br>FEB. 14, 1997  |  | 3. Time of Death<br>0434AM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>PHYSICIANS MEMORIAL HOSPITAL  |  |  |  | 4b. City, Town, or Location of Death<br>La PLATA   |  | 4c. County of Death<br>CHARLES  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>217-44-7120  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>50 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>MAY 9, 1946  |  |
|   | 9. Birthplace (State or Foreign Country)<br>MARYLAND  |  | 10a. State<br>MARYLAND   |  | 10b. County<br>CHARLES   |  | 10c. City, Town or Location<br>PISGAH   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>BOX 5 STUCKEY ROAD   |  | 10f. Zip Code<br>20640   |  | 10g. Citizen of What Country?<br>UNITED STATES  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br>12TH GRADE   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>TRUCK DRIVER  |  | 16b. Kind of Business/Industry<br>TRASH REMOVAL  |  | 17. Father's Name (First, Middle, Last)<br>EARL BENJAMIN KEY  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br>MARTHA FORD KEY  |  | 19a. Informant's Name/Relationship (Type, Print)<br>GERALDINE KEY / WIFE   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>BOX 5 STUCKEY ROAD, INDIAN HEAD, MARYLAND 20640   |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  |
| Physician<br>/Medical<br>Examiner             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>SMITH CHAPEL CHURCH CEM.  |  | 20c. Location - City or Town, State<br>PISGAH, MARYLAND  |  | 21. Signature of Funeral Service Licensee<br><i>Sydia C. Thornton Johnson</i>  |  | 22. Name and Address of Facility<br>THORNTON FUNERAL HOME, P.A.<br>3439 LIVINGSTON ROAD, INDIAN HEAD, MD. 20640   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Myocardial infarction</i><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |
|   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |   |  |
| State Registrar                               | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>Donald G. Wright MD</i>   |  |
| To Be Completed by Physician/Medical Examiner | 29c. License number<br>O.C.M.E  |  | 29d. Date signed (Month, Day, Year)<br>FEB. 15, 1997   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201   |  | 31. Date filed (Month, Day, Year)<br>FEB 19 1997  |  |
|   | 32. Registrar's Signature<br><i>John Davidson Randall</i>   |  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.


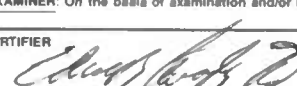

Medical Certification: To Be Completed by Physician/Medical Examiner



97 06169

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |   |  |   |   |  |
|--|--|--|---|---|---|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Howard Haller KNODE  |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 13, 1997   |   |  |   | 3. TIME OF DEATH<br>11:20 a. M  |  |
| 4. SOCIAL SECURITY NUMBER<br>219-07-6999   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>84 YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN.                              | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>July 9, 1912                               |   | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br>Clearview Nursing Home   |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown   |   |  | 9c. COUNTY OF DEATH<br>Washington                                   |   |  |
| RESIDENCE OF DECEDENT  |  |  |   |   |   |  |   |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Washington  |   | 10c. CITY, TOWN OR LOCATION<br>Hagerstown   |   |  |   | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>1114 S. Potomac Street   |  |  |   | 10f. ZIP CODE<br>21740  |   | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |   |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>white |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0  |  |  |   | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Machine molder foundry workman   |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>molten metal                      |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Howard Clarence Knode   |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Alta Jane Haller   |   |  |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Galen W. Knode   |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P. O. Box 185, Churchton, Md. 20733  |   |  |   |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Rest Haven Cemetery 2-17-97   |   |   | 20c. LOCATION — City or Town, State<br>Hagerstown, Maryland |  |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>MINNICH FUNERAL HOME<br>415 E. Wilson Blvd., Hagerstown, Md. 21740  |   |  |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |   |   |   |  |   |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Compensatory heart failure</u><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |   |   |   |  |   |   |  |
| b. <u>Recent myocardial infarction</u><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |   |   |   |  |   |   |  |
| c. <u>Chronic obstructive pulmonary disease</u><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |   |   |   |  |   |   |  |
| d. _____   |  |  |   |   |   |  |   |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |   |   |   |  |   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Chronic myocardial infarction; recent right ventricular infarction; hypertension</u>  |  |  |   |   |   |  |   |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |   |   |   |  |   |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |   |   |   |  |   |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |   |   |   |  |   |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |   |  |   |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |   | 28b. TIME OF INJURY<br>M  |   | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
|  |  | 28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)   |   |   |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |   |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |   |   |  |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |   | 29c. LICENSE NUMBER<br>101857   |   | 29d. DATE SIGNED (Month, Day, Year)<br>2/13/97                                       |   |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Edson B. Moody, M. D., 1190 Mt. Aetna Rd., Hagerstown, Md. 21740  |  |  |   |   |   |  |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 14 1997   |  |  |   | 32. REGISTRAR'S SIGNATURE<br>  |   |  |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06170

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hazel P. AKA HAZEL P. KOLLMORGEN  
Kollmorgan

2. Date of Death

Month Day Year  
Feb 17 1997

3. Time of Death

8:15PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Genesis ElderCare - The Pines

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

213-03-9799

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
10/14/07

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Caroline

10c. City, Town or Location

Federalsburg

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

336 East Central Avenue

10f. Zip Code

21632

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

+2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Montgomery Ward  
MD Plastics

17. Father's Name (First, Middle, Last)

Joseph Hall Poyner

18. Mother's Name (First, Middle, Maiden Surname)

Mary Gambrill

19a. Informant's Name/Relationship (Type, Print)

Pauline P. Tuckett

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

210 Vesper Avenue, Federalsburg, MD 21632

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hill Crest Cemetery 2/21

Date

20c. Location - City or Town, State

Federalsburg, MD

21. Signature of Funeral Service Licensee

Michael F. Eskow

22. Name and Address of Facility

Frampton-Hawkins-Eskow Funeral Home  
PO Box 43, Federalsburg, MD 21632

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dementia, progressive

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cerebrovascular insufficiency

Due to (or as a consequence of):

years

c. Atherosclerosis

Due to (or as a consequence of):

years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michael F. Eskow

29c. License number

D25933

29d. Date signed (Month, Day, Year)

2-18-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

308 Idlewild Avenue

Easton, MD

21601

MICHAEL CROWLEY MD

31. Date filed (Month, Day, Year)

FEB 21 97

32. Registrar's Signature

Sandra Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

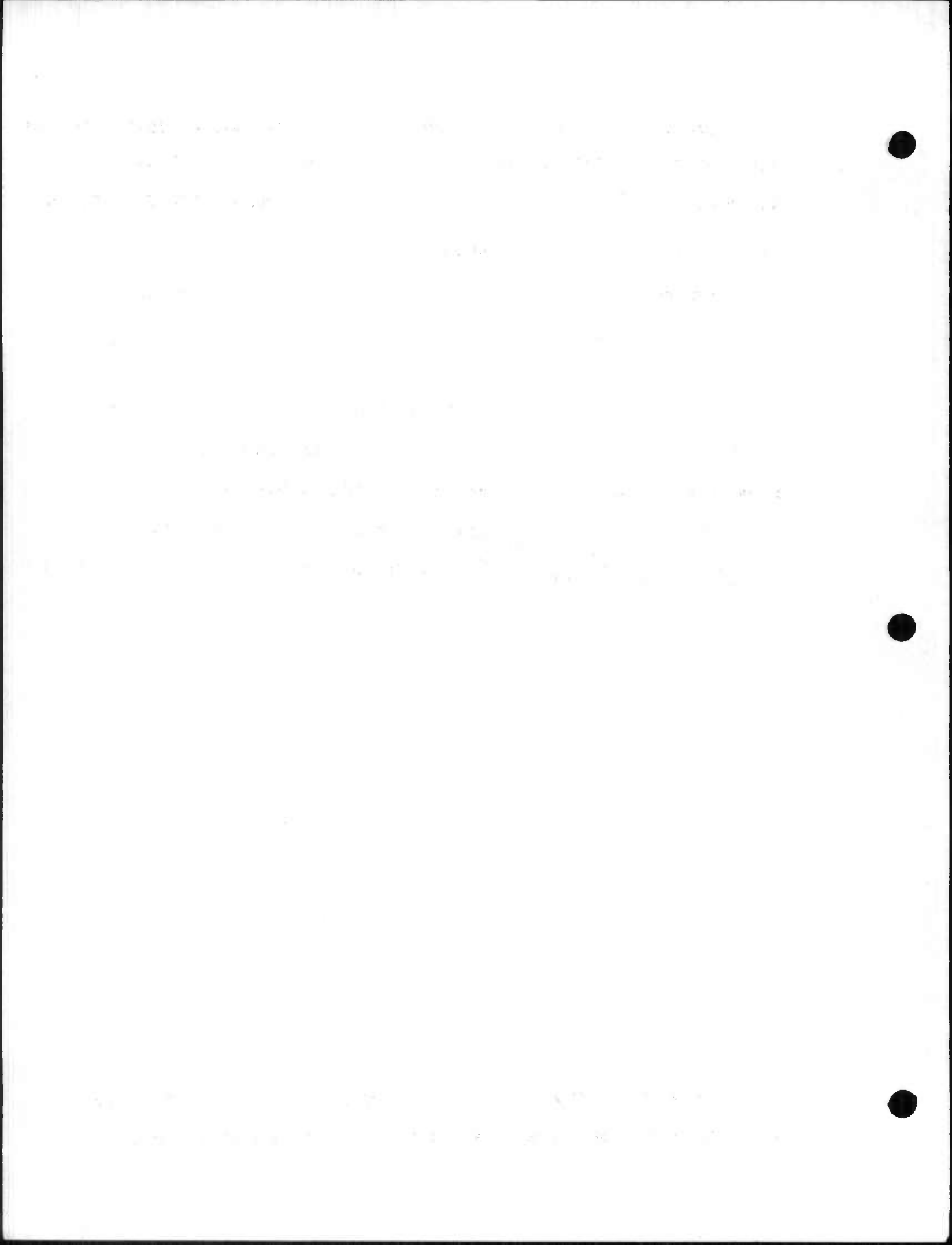
Reg. No.

97 06171

|   |   |   |   |  |  |   |   |  |   |   |  |  |  |
|---|---|---|---|--|--|---|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES A. LONG</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>February 12 1997</b>  |   | 3. Time of Death<br><b>12:55 PM</b>                                     |  |   |   |  |  |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>BERLIN NURSING &amp; REHAB. CENTER</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>BERLIN</b>  |   | 4c. County of Death<br><b>WORCESTER</b>                                 |  |   |   |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>509-22-3931</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.                             | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>JULY 15, 1929</b>             | 9. Birthplace (State or Foreign Country)<br><b>CAMERON, MO.</b>                                |   |   |  |  |  |
|   | Usual Residence of Decedent   |   |   |  |  |   |   |  |   |   |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD.</b>  |   | 10b. County<br><b>WICOMICO</b>  |  | 10c. City, Town or Location<br><b>SALISBURY</b>  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   |  |  |  |
|   | 10e. Street and Number<br><b>6853 LOIS AVENUE</b>   |   |   |  | 10f. Zip Code<br><b>21804</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |   |   |  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever In U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WW II</b><br>If Yes, Give Year or Dates: <b>KOREA</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |   |   |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br><b>2</b>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>NEWSPAPER CARRIER</b>  |   | 16b. Kind of Business/Industry<br><b>SELF-EMPLOYED</b>                  |  |   |   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>SAMUEL ALLEN LONG</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>RUBY FRANCES COUSIN</b>  |   |   |  |   |   |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>BERNADETTE LONG -WIFE</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6853 LOIS AVENUE, SALISBURY, MD. 21804</b>   |   |   |  |   |   |  |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CAMBRIDGE CREMATORY</b>  |  | Date   |   | 20c. Location - City or Town, State<br><b>CAMBRIDGE, MD.</b>            |  |   |   |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>BOUNDS FUNERAL HOME, SALISBURY, MARYLAND 21804</b>  |   |   |  |   |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |   |   |  |   |   |  |  |  |
|   | <table border="1"> <tr> <td rowspan="4">           Immediata Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a. <u>Alzheimer's Disease</u><br/>Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death<br/><u>Yes</u></td> </tr> <tr> <td>b. _____<br/>Due to (or as a consequence of):</td> </tr> <tr> <td>c. _____<br/>Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____<br/>Due to (or as a consequence of):</td> </tr> </table> |   |   |  |  |   |   |  | Immediata Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. <u>Alzheimer's Disease</u><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death<br><u>Yes</u> | b. _____<br>Due to (or as a consequence of): | c. _____<br>Due to (or as a consequence of): |
| Immediata Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   | a. <u>Alzheimer's Disease</u><br>Due to (or as a consequence of):   | Approximate Interval Between Onset and Death<br><u>Yes</u>  |   |  |  |   |   |  |   |   |  |  |  |
|   | b. _____<br>Due to (or as a consequence of):  |   |   |  |  |   |   |  |   |   |  |  |  |
|   | c. _____<br>Due to (or as a consequence of):  |   |   |  |  |   |   |  |   |   |  |  |  |
|   | d. _____<br>Due to (or as a consequence of):  |   |   |  |  |   |   |  |   |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Organic Arteriosclerosis</u><br><u>Mental Incompetence</u>   |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |   |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |   |   |  |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |   |  |   |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   | 28d. Describe how injury occurred  |   |   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |   |  |   |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |  |   |   |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br>   |   |   |   | 29c. License number<br><b>D02026</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>Feb 12-97</b>   |   |  |   |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>DR. FEDERICO G. ARTES 1622A OCEAN PINES, BERLIN, MD 21811 410-641-4400</b>   |   |   |   |  |  |   |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 14 1997</b>   |   |   |   | 32. Registrar's Signature<br>  |  |   |   |  |   |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06172

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LINDSAY ANNE

2. Date of Death

Month

Day

Year

FEBRUARY 11, 1997

3. Time of Death

0005

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

462-33-5441

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

22

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
October 10, 1974

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

926 Snow Hill Rd.

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
-16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Martin Joseph Kentfield

18. Mother's Name (First, Middle, Maiden Surname)

Lynne Carol Stange

19a. Informant's Name/Relationship (Type, Print)

Martin &amp; Lynne C. Kentfield/parents

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1327 Craghill Court, Hanover, MD 21076-1452

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Salisbury Crematory

Date

2/13/97

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

M01051

22. Name and Address of Facility

Holloway Funeral Home

501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. pneumonia

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Corneille de Lange's Syndrome.

Seizure Disorder.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D01546

29d. Date signed (Month, Day, Year)

2/11/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

I. D. Nardo M.D. 106 MILFORD ST SALISBURY, MD 21801

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

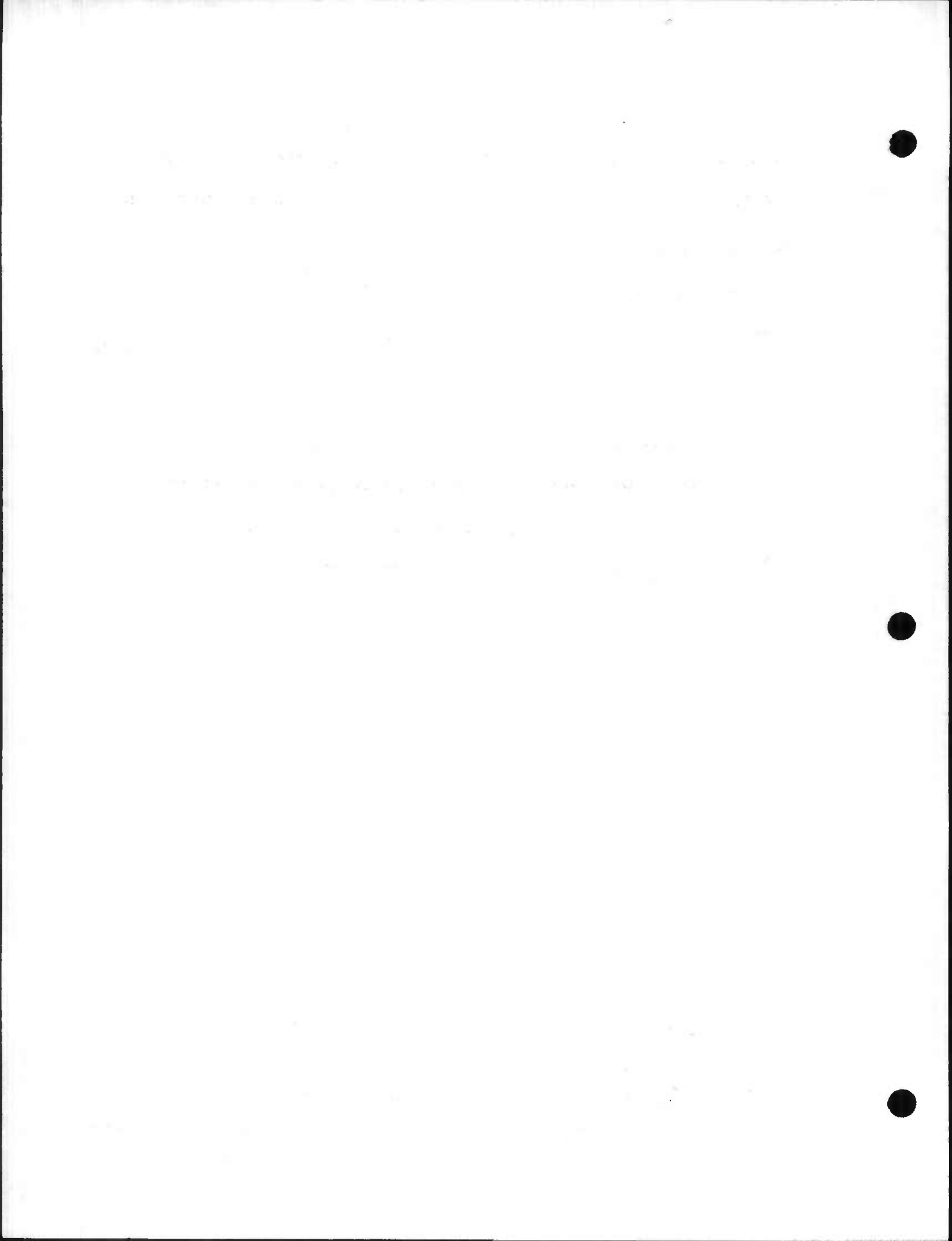
State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06173

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY MARGUERITE LOHMAN

2. Date of Death

FEBRUARY 16, 1997

Day

Year

3. Time of Death  
11:42 pm

4a. Facility Name (If not institution, give street and number)

Williamsport Nursing Home

4b. City, Town, or Location of Death

Williamsport

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

194-28-8586

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

APR 17, 1912

9. Birthplace (State or Foreign Country)

Shippensburg, PA

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Clear Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12512 Rockdale RD

10f. Zip Code

21722

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

18a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Beautician

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Benjamin Van Sayoc

18. Mother's Name (First, Middle, Maiden Surname)

Martha Gipe

19a. Informant's Name/Relationship (Type, Print)

Charles D. Lohman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11391 Meeting House RD Myersville MD 21773

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

C. V. Crematorium

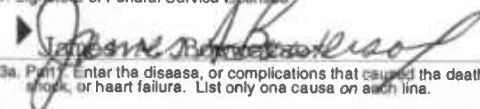
Date

2/19

20c. Location - City or Town, State

Waynesboro PA 17268

21. Signature of Funeral Service Licensee

22. Name and Address of Facility  
Grove Funeral Home, Inc.  
Minnich-Miller May FH Greencastle PA 17225  
50 S. Broad ST Waynesboro PA 1726823a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. SEPTIC SHOCK

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

24 HOURS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPER GLYCEMIA, HYPEROSMOLAR COMA

ACUTE CEREBRAL INFARCT.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

 MD

29c. License number

D33700

29d. Date signed (Month, Day, Year)

FEBRUARY 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TED HOWE 7542 OVERLOOK DRIVE, BOONSBORO, MD 21713

31. Date filed (Month, Day, Year)

FEB 20 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





97 06174

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Alice Evelyn Long</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>February</b> DAY <b>15</b> , YEAR <b>1997</b>  |  | 3. TIME OF DEATH<br><b>4:15 a m</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>135 07 9698</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>October 16, 1913</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>New Jersey</b>                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Clearview Nursing Home</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>  |  | 9c. COUNTY OF DEATH<br><b>Washington</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Washington</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>18630 Crestwood Drive</b>  |  |   |  | 10f. ZIP CODE<br><b>21742</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Senior Analyst</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Insurance</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Francis A. Long</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Helen Evelyne</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Kathleen A. Rowe</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>18630 Crestwood Drive Hagerstown, Md. 21742</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of place, crematory or other place)<br><b>Gate of Heaven Cemetery 2/19/97</b>  |  | 20c. LOCATION — City or Town, State<br><b>Hanover, N. J.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Gerald N. Minnich</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Gerald N. Minnich 305 N. Potomac St.<br/>Funeral Home Hagerstown, Maryland</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acute bronchopneumonia</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <b>b. Organic brain syndrome</b><br><b>c. Dementia</b><br><b>d.</b> |  |   |  |   |  |   | Approximate interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>PH4131</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/15/97</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JERRY L. CORRELLS, M.D.<br/>338 Mill St. Hagerstown MD 21740</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 20 1997</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 m.c.  
2/21

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06175

## Certificate of Death

Reg. No.

|  |  |   |  |   |  |  |  |  |  |   |  |   |  |
|--|--|---|--|---|--|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>John Passmore Logan                                  |   |  |   |  |  | 2. Date of Death<br>Month Day Year<br>February 13, 1997          |  | 3. Time of Death<br>12:20 p.m.                       |   |  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Union Hospital of Cecil County |   |  |   | 4b. City, Town, or Location of Death<br>Elkton |  | 4c. County of Death<br>Cecil                                     |  |  |   |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>217-26-6732   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>71 Yrs.      |  | 8. Date of Birth (Month, Day, Year)<br>June 22, 1925             |  | 9. Birthplace (State or Foreign Country)<br>Maryland |   |  |   |  |
|  | Usual Residence of Decedent  |   |  |   |  |  |  |  |  |   |  |   |  |
| 10a. State<br>Maryland   |  | 10b. County<br>Cecil  |  | 10c. City, Town or Location<br>North East   |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  |
| 10e. Street and Number<br>160 Piney Ridge Lane   |  |   |  | 10f. Zip Code<br>21901  |  | 10g. Citizen of What Country?<br>United States                                       |  |  |  |   |  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1942-1946 |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |   |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>owner/operator/sales   |  |  | 18b. Kind of Business/Industry<br>Retail appliance sales store   |  |  |   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br>Howard P. Logan, Sr.  |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elizabeth Jane Collings         |  |  |  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Dorothy W. Logan / Spouse  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>160 Piney Ridge Lane, North East, Maryland 21901   |  |  |  |  |  |   |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>North East Methodist Cem.   |  | Date<br>Feb. 13, 1997   |  | 20c. Location - City or Town, State<br>North East, Maryland                          |  |  |  |   |  |   |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br>Crouch Funeral Home<br>127 South Main Street, North East, MD 21901  |  |  |  |  |  |   |  |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>ASPIRATION PNEUMONIA</u><br>Due to (or as a consequence of):<br>b. <u>CAD</u><br>Due to (or as a consequence of):<br>c. <u>HYPOXEMIA</u><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |   |  |   |  |
|  |  |   |  |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 28. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |   |  |   |  |
|  |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>                                    |  |   |  |  |  |  |  | 29c. License number<br>D 32395  |  | 29d. Date signed (Month, Day, Year)<br>02-13-97 |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Thomas E. Finucan 3 Mauldin Avenue, North East MD 21901  |  |   |  |   |  |  |  |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br>FEB 14 1997   |  |   |  | 32. Registrar's Signature<br>  |  |  |  |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06176

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bonita Leray

2. Date of Death

February 12, 1997

3. Time of Death

11:30am

4a. Facility Name (If not institution, give street and number)

Mercy Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

None

Funeral  
Director

5. Social Security Number

087-42-8063

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

46 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

October 6, 1950

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9025 Thamesmeade Road Apt. B

10f. Zip Code

20723

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Graphic Designer

16b. Kind of Business/Industry

Grocery

17. Father's Name (First, Middle, Last)

Joseph LeRoy

18. Mother's Name (First, Middle, Maiden Surname)

Doris Berghauser

19a. Informant's Name/Relationship (Type, Print)

Theodore F. Hammer/Executor

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9025 Thamesmeade Road Apt B Laurel, Maryland 20723

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Balt-Washington Crematory 2-14-97 Laurel, Maryland

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Harry H. Witzke

22. Name and Address of Facility

Harry H. Witzke Funeral Home, Inc.

4112 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Adenocarcinoid Carcinoma Appendix 6 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Marvin J. Feldman MD

Attending

29c. License number

D07930

29d. Date signed (Month, Day, Year)

February 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marvin J. Feldman, MD 301 St. Paul Place Baltimore, MD, 21202

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06177

|   |  |  |   |  |   |  |  |  |
|---|--|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>CECIL FILMORE LEWIS SR.  |  |   |  | 2. Date of Death<br>02 Month 12 Day 97 Year   |  | 3. Time of Death<br>3:55 AM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>708 Lakeside Drive   |  |   |  | 4b. City, Town, or Location of Death<br>Salisbury   |  | 4c. County of Death<br>Wicomico  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>227-05-0952   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>90 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>11 27 06                                      |  |
|   | 9. Birthplace (State or Foreign Country)<br>Virginia   |  | 10a. State<br>MD  |  | 10b. County<br>Wicomico   |  | 10c. City, Town or Location<br>Salisbury   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>708 Lakeside Drive  |  | 10f. Zip Code<br>21801  |  | 10g. Citizen of What Country?<br>USA   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 1<br>College (1-4 or 5+) 1  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Owner                                    |  | 16b. Kind of Business/Industry<br>Steel Products  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Lloyd Filmore Lewis   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Maude Hurst  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Alma V. Lewis-Spouse   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>708 Lakeside Drive, Salisbury, MD 21801  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Onancock Cemetery   |  | 20c. Location - City or Town, State<br>Onancock, Virginia   |  | 20d. Date<br>2/16/97   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>David H. Thompson</i>  |  | 22. Name and Address of Facility<br>Holloway Funeral Home, P.A.<br>501 Snow Hill Road, Salisbury, MD 21804  |  |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Cerebrovascular Accident</i><br>Due to (or as a consequence of):<br>b. <i>Atherosclerotic Cardiovascular Disease</i><br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |   |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |  |   |  |  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.   |  |   |  |   |  |  |  |
| State<br>Registrar                            | 29b. Signature and title of certifier<br><i>Allen W. Tustin, M.D.</i>  |  |   |  | 29c. License number<br>D 22996  |  | 29d. Date signed (Month, Day, Year)<br>February 12, 1997                             |  |
|   | 30. Name and address of person who completed cause of death (item 23e) (Type, Print)<br><i>Allen W. Tustin, M.D., 105 Pine Bluff Rd, Ste 1A, Salisbury, MD 21801</i>   |  |   |  |   |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br>FEB 14 1997   |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06178

Reg. No.

|   |  |   |  |  |  |   |  |   |   |   |  |   |  |
|---|--|---|--|--|--|---|--|---|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>VIRGINIA MILLER</b>   |   |  |  |  |   | 2. Date of Death<br>Month <b>2</b> Day <b>12</b> Year <b>97</b>                                |   | 3. Time of Death<br><b>2100</b>                       |   |  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Gull Creek Assisted Living #1 Meadow St</b> |   |  |  |  |   | 4b. City, Town, or Location of Death<br><b>Berlin, Md</b>                                      |   | 4c. County of Death<br><b>Worcester</b>               |   |  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>065-12-7306</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs. |   | 8. Date of Birth (Month, Day, Year)<br><b>2-26-20</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>NY</b> |   |  |   |  |
|   | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>WORCESTER</b>  |  | 10c. City, Town or Location<br><b>BERLIN, MD</b> |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |   |   |  |   |  |
| 10e. Street and Number<br><b>1 MEADOW STREET</b>  |  | 10f. Zip Code<br><b>21811</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:         |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SCHOOL BUS MONITOR</b>   |  | 16b. Kind of Business/Industry<br><b>STATE</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>CHARLES D. BUNT</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FRANCES MCKEE</b>   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>VIRGINIA RUSH</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>54 CREST HAVEN DR BERLIN, MD.</b>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>RAYMOND HILL CEMETARY 2-17 CARMEL, NEW YORK</b>  |  | 20c. Location - City or Town, State   |   | 21. Signature of Funeral Service Licensee<br>   |  |   |  |
| 22. Name and Address of Facility<br><b>ULLRICH FUNERAL HOME BERLIN, MD. 21811</b>   |  | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Metastatic Breast Cancer</b><br><br>Due to (or as a consequence of):<br><b>COPO</b><br><br>Due to (or as a consequence of):<br><b>ASEVD</b><br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><b>Months</b><br><br><b>Years</b><br><br><b>Years</b> |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                   |   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Retirement Community</b> |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how Injury occurred   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>028769</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2/12/97</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>NICHOLAS N. BORODOULI, M.D. #1 MEADOW ST, BERLIN, MD 21811</b> |   | 31. Date filed (Month, Day, Year)<br><b>FEB 14 1997</b>   |  |   |  |
| 32. Registrar's Signature<br>   |  |   |  |  |  |   |  |   |   |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



**Physician  
/Medical  
Examiner**

## Funeral Director

**Baltimore, Maryland 21215-0020**

permitted. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

|   |  |   |                               |   |  |  |   |  |  |
|---|--|---|-------------------------------|---|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Helen Marie Mills</b>  |  |   |                               |   |  | 2. Date of Death<br>Month Day Year<br><b>Feb 13 1997</b>   |   | 3. Time of Death<br><b>23 15 pm</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Washington County Hospital</b>   |  |   |                               |   |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>  |   | 4c. County of Death<br><b>Washington</b>   |  |
| 5. Social Security Number<br><b>220-28-7718</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                               | 7. Age (In yrs. last birthday) Yrs.<br><b>86</b>  |  | 8. Date of Birth (Month, Day, Year)<br><b>October 1, 1910</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>PA</b>  |  |
| Usual Residence of Decedent   |  |   |                               |   |  |  |   |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Washington</b>  |                               | 10c. City, Town or Location<br><b>Hagerstown</b>  |  |  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>43A Elgin Blvd.</b>  |  |   |                               |   |  | 10f. Zip Code<br><b>21740</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b><br>College (1-4 or 5+) _____  |  |   |                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cook</b>  |  |  | 16b. Kind of Business/Industry<br><b>Medical</b>                        |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>George Henry Ruben Carbaugh</b>   |  |   |                               |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Phoebe Frances Paylor</b>  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Susan R. Hornbaker/Daughter</b>  |  |   |                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13820 Blairs Valley Rd. Mercersburg, PA 17236</b>   |  |  |   |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Clear Spring Menn. Ch. Cem. 2-17-97 Clear Spring, MD</b>   |                               | Date  |  | 20c. Location - City or Town, State  |   |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |                               | 22. Name and Address of Facility<br><b>Osborne Funeral Home<br/>425 S. Conococheague St. Williamsport, MD 21795</b>   |  |  |   |  |  |
| 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Septicemia</b><br>Due to (or as a consequence of):<br>b. <b>Cholangitis</b><br>Due to (or as a consequence of):<br>c. <b>Common Bile Duct Obstruction</b><br>Due to (or as a consequence of):<br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { |  |   |                               |   |  |  |   | Approximate Interval Between Onset and Death<br><b>days</b><br><b>days</b><br><b>months</b>        |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                               |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |  |  |
|   |  |   |                               |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |
|   |  |   |                               |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                               |   |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |                               | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |                               |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |                               |   |  |  |   |  |  |
| 29b. Signature and title of certifier<br>   |  |   |                               | 29c. License number<br><b>D11133</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>Feb 14, 1997</b>   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Charles C. SPENCER 1110 Medical Campus Rd Hagerstown MD</b>  |  |   |                               |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 18 1997</b>   |  |   | 32. Registrar's Signature<br> |   |  |  |   |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06180

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GERALD ORVEY MILLER

2. Date of Death

February 16, 1997

Day

Year

3. Time of Death

2:45 pm

4a. Facility Name (If not institution, give street and number)

WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death

HAGERSTOWN

4c. County of Death

WASHINGTON

5. Social Security Number

214-09-8243

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAY 7, 1918

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WASHINGTON

10c. City, Town or Location

HAGERSTOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10804 DOWNSVILLE PIKE

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1942-

1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SERVICE MANAGER

16b. Kind of Business/Industry

AUTOMOBILE DEALER

17. Father's Name (First, Middle, Last)

GARDNER BOOTH MILLER

18. Mother's Name (First, Middle, Maiden Surname)

MARY BEAUFORD

19a. Informant's Name/Relationship (Type, Print)

PHYLLIS S. MILLER/SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10804 DOWNSVILLE PIKE, HAGERSTOWN, MD 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BOONSBORO CEMETERY

Date

2/19/97

20c. Location - City or Town, State

BOONSBORO, MARYLAND

21. Signature of Funeral Service Licensee

Paul M. Dean

22. Name and Address of Facility

Paul M. Dean BAST FUNERAL HOME  
7606 Old National Pike  
Boonsboro, MD 21713

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Pneumonia

Due to (or as a consequence of):

b.

Acute Intestinal Bleed

Due to (or as a consequence of):

c.

Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

7 weeks

1 week

Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Iqbal

MD.

29c. License number

D47288

29d. Date signed (Month, Day, Year)

Feb 18, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Iqbal 12821 Oak Hill Ave. Hager, MD 21742

31. Date filed (Month, Day, Year)

FEB 19 1997

32. Registrar's Signature

John Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06181

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Susanna Elizabeth Mills

2. Date of Death

Month Day Year  
Feb. 16 1997 2:53

3. Time of Death

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

214-16-1373

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 3, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Clear Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14004 Mercersburg Road

10f. Zip Code

21722

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
0-6College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Ignatius Samuel Drury

18. Mother's Name (First, Middle, Maiden Surname)

Anna Virginia Henson

19a. Informant's Name/Relationship (Type, Print)

Mrs. Lorraine Bigler

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14004 Mercersburg Road, Clear Spring Maryland 21722

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Clear Spring Mennonite  
Church Cemetery

Date

Feb 19, 1997 Clear Spring, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

▶ *Scott M. Minnich*

22. Name and Address of Facility

Minnich Funeral Home

15 East Wilson Blvd., Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

*congestive heart failure*

Due to (or as a consequence of):

b.

*coronary heart artery disease*

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death5 day  
years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*systemic embolization from left atrial thrombus*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

▶ *R. Guedenet*

29c. License number

D32518

29d. Date signed (Month, Day, Year)

2-16-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. R. Guedenet 100 Geeting Lane Keedysville, Md

31. Date filed (Month, Day, Year)

FEB 20 1997

32. Registrar's Signature

*John H. Hester*State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06182

## Certificate of Death

Reg. No.

|   |  |   |  |  |   |   |  |   |
|---|--|---|--|--|---|---|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Vernon E. Matthews Jr.</b>                            |   |  |  | 2. Date of Death<br>Month <b>2</b> Day <b>10</b> Year <b>97</b> |   | 3. Time of Death<br><b>2010</b>  |   |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Dorchester General Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Cambridge</b>        |   | 4c. County of Death<br><b>Dorchester</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-66-8806</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>42</b> Yrs.   | If Under 1 Year<br>Months Days                                  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>12/12/54</b>   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |
|   | Usual Residence of Decedent  |   |  |  | 10c. City, Town or Location<br><b>Vienna</b>                    |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Dorchester</b>  |  | 10e. Street and Number<br><b>4852 Craft Road</b>   |   | 10f. Zip Code<br><b>21869</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                     |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>  |   | 16b. Kind of Business/Industry<br><b>Pickle Processing</b>                                  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Vernon E. Matthews, Sr.</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Epluribus Unum Davis</b>   |   |   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Vernon Matthews, Sr./Father</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4852 Craft Rd., Vienna, MD 21869</b>   |   |   |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Thompsons town Cem.</b>   |   | 20c. Location - City or Town, State<br><b>Tnompsons town, MD</b>                            |  |   |
| 21. Signature of Funeral Service Licensee<br><b>Michael F. Eskow</b>  |  |   |  | 22. Name and Address of Facility<br><b>Frampton-Hawkins-Eskow Funeral Home<br/>PO Box 43, Federalsburg, MD 21632</b>   |   |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |   |   |  | Approximate Interval Between Onset and Death  |
| Immediate Cause (Final disease or condition resulting in death)<br><b>a. Caroline Argythemia</b>  |  |   |  |  |   |   |  | <b>4 min</b>  |
| Due to (or as a consequence of):<br><b>b. Chronic Alcoholism</b>  |  |   |  |  |   |   |  |   |
| Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |  |  |   |   |  |   |
| Due to (or as a consequence of):<br><b>c.</b>   |  |   |  |  |   |   |  |   |
| Due to (or as a consequence of):<br><b>d.</b>   |  |   |  |  |   |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred   |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |  |   |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Dr. J. H. Hadden</b>  |  | 29c. License number<br><b>D20388</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>02-13-1997</b>                                    |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Mr. J. H. Hadden MD 300 Collins Hurlock md 21643</b>   |  |   |  |  |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 18 97</b>   |  | 32. Registrar's Signature<br><b>J. H. Hadden</b>  |  |  |   |   |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 63760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06183

Items: 23 part I, II, 27 per ME0 G-745 3/11/97 <sup>Feb</sup> Certificate of Death

Reg. No.

|   |   |  |  |  |   |  |  |   |
|---|---|--|--|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>FREDRICA MOSS</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>FEB. 10, 1997</b>  |  | 3. Time of Death<br><b>0847 AM</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SOUTHERN MARYLAND HOSPITAL CENTER</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>CLINTON</b>  |  | 4c. County of Death<br><b>PRINCE GEORGES</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>272-58-0557</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>39</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Oct 21, 1957</b>   | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b> |
|   | Usual Residence of Decedent   |  |  |  |   |  |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Prince George</b>  |  | 10c. City, Town or Location<br><b>Mount Rainier</b>   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |
|   | 10e. Street and Number<br><b>4301 Kaywood Drive</b>   |  |  |  | 10f. Zip Code<br><b>20712</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>2</b>  |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerk</b>   |  | 16b. Kind of Business/Industry<br><b>Grocery Store</b>  |  |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Fred Moss</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rose Hart</b>   |  |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Rose Moss Mother</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2065 Sturgeon St. Springfield, Ohio 45506</b>   |  |  |   |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rose Hill Burial Park</b>   |  | 20c. Location - City or Town, State<br><b>2/15/97 Springfield, Ohio</b>   |  |  |   |
|   | 21. Signature of Funeral Service Licensee<br>   |  |  |  | 22. Name and Address of Facility<br><b>Donaldson Funeral Home, P.A.<br/>313 Talbott Ave. Laurel, Maryland 20707-4389</b>  |  |  |   |
|   | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death) <b>ASTHMA</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |   |  |  |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SARCROID</b>   |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |
|   |   |  |  |  |   | 24e. Was an autopsy performed?<br><b>XX</b> Yes 2 <input type="checkbox"/> No  |  |   |
|   |   |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>XX</b> Yes 2 <input type="checkbox"/> No |  |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 25. Was case referred to medical examiner?<br><b>XX</b> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28d. Describe how injury occurred   |  |  |   |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |   |
|   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |   |  |  |   |
| 29b. Signature and title of certifier<br>                                  |   |  |  | 29c. License number<br><b>O.C.M.E</b>            |   | 29d. Date signed (Month, Day, Year)<br><b>FEB. 11, 1997</b>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. DAVID R. FOWLER 111 Penn Street, Baltimore, Maryland 21201</b> |   |  |  |  |   |  |  |   |
| State Registrar   | 31. Date filed (Month, Day, Year)<br><b>FEB 13 1997</b>   |  |  |  | 32. Registrar's Signature<br>  |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06184

|   |  |  |   |   |  |   |  |  |
|---|--|--|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>EVELYN A. MARABLE</b>   |  |   |   | 2. Date of Death<br>Month Day Year<br><b>Feb. 17, 1997</b>   |   | 3. Time of Death<br><b>5A.M.</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>28000 HICKMAN LANE</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>NANTICOKE</b>   |   | 4c. County of Death<br><b>WICOMICO</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>168-12-1628</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>2/18/1921</b>  | 9. Birthplace (State or Foreign Country)<br><b>Md.</b> |
|   | Usual Residence of Decedent  |  |   |   |  |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>Wicomico</b>  |   | 10c. City, Town or Location<br><b>Nanticoke</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>4197 Jesterville Rd.</b>  |  |   |   | 10f. Zip Code<br><b>21865</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>House Wife</b>                    |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Ezekie Church</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lola -----</b>   |   |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Timothy Marable</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4197 Jesterville Rd, Tyaskin, Md 21865</b>   |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Haven Mem. Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>Pa.</b>  |   | 20d. Location - City or Town, State<br><b>Chester Township,</b>                                |  |
|   | 21. Signature of Funeral Service Licensee<br><b>MOO-417</b><br><i>Conrad M. Mesent</i>   |  | 22. Name and Address of Facility<br><b>Messick Funeral Home, P.O. Box 61<br/>Bivalve, Maryland 21814</b>  |   |  |   |  |  |
|   | 23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Acute Myocardial Infarction</b><br>Due to (or as a consequence of):<br><br>b. <b>Severe Coronary Artery Disease</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |   |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Renal Failure</b>  |  |  |   |   |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)                       |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                      |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Bert S. Chan</b> |   | 29c. License number<br><b>D-20050</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2/18/97</b>                                       |  |  |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>BENITO S. CHAN 547-D Riverside Dr. Solby, MD 21861</b>   |  |  |   |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 18 1997</b>   |  | 32. Registrar's Signature<br><i>John Davidson Randall</i>    |   |   |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06185

Reg. No.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>WOODROW WILSON   |  | 2. Date of Death<br>Month: February, Day: 12, Year: 1997   |   | 3. Time of Death<br>0137   |
|  | 4a. Facility Name (If not institution, give street and number)<br>PENINSULA REGIONAL MEDICAL CENTER  |  | 4b. City, Town, or Location of Death<br>SALISBURY  |   | 4c. County of Death<br>WICOMICO                                  |
| Funeral<br>Director  | 5. Social Security Number<br>219-14-3601   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>77 Yrs.  | If Under 1 Year<br>Months: Days:  | If Under 24 Hrs.<br>Hours: Min.                                  |
|  | 8. Date of Birth (Month, Day, Year)<br>JAN. 5, 1920  |  | 9. Birthplace (State or Foreign Country)<br>MD.  |   |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
|  | 10a. State<br>MD.  | 10b. County<br>WICOMICO  | 10c. City, Town or Location<br>SALISBURY   |   |  |
|  | 10e. Street and Number<br>27353 WALNUT TREE ROAD   |  | 10f. Zip Code<br>21801   |   | 10g. Citizen of What Country?<br>U.S.A.                          |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WW II<br>If Yes, Give Year or Dates: ARMY |   | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): 12<br>College (1-4 or 5+):   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>CARPENTER                                       |   | 16b. Kind of Business/Industry<br>SELF-EMPLOYED                  |
|  | 17. Father's Name (First, Middle, Last)<br>JEROME C. MALONE  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>FLORENCE HILDA SMITH  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>WOODROW MALONE - SON   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5079 CAMPGROUND ROAD, EDEN, MARYLAND 21822                  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>SILOAM CEMETERY  |   | 20c. Location - City or Town, State<br>2/15/97 SILOAM, MD.       |
|  | 21. Signature of Funeral Service Licensee<br><i>Gerald C. Bounds</i>   |  | 22. Name and Address of Facility<br>BOUNDS FUNERAL HOME, SALISBURY, MD. 21804  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Coronary artery disease</i><br>Due to (or as a consequence of):<br>b. <i>COVID</i><br>Due to (or as a consequence of):<br>c. <i>Non-invasive laparoscopic DM</i><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred                                |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>John K. McLean</i>   |  |   |  |
| 29c. License number<br>D25209  |  | 29d. Date signed (Month, Day, Year)<br>2/12/97   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>JOHN McLEAN M.D. 106 MILFORD ST SALISBURY, MD 21801  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>FEB 14 1997   |  | 32. Registrar's Signature<br><i>John Davidson Randall</i>  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

31 VA

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

97 06186

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred Katherine Nowell

2. Date of Death

February 13, 1997

3. Time of Death

6:10 P. M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Avalon Manor Nursing Home

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

219-34-5137

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Sept. 30, 1911

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

1009 Lindsey Lane

10f. Zip Code

21742

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

18e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

home

17. Father's Name (First, Middle, Last)

Rolla Overcash

18. Mother's Name (First, Middle, Maiden Surname)

Annie Bertha Grove

19a. Informant's Name/Relationship (Type, Print)

Nancy L. Kauffman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1009 Lindsey Lane Hagerstown, Maryland 21742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Rest Haven Cemetery

Date

2/17/97

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

*Gerald N. Minnich*

22. Name and Address of Facility

Gerald N. Minnich

Funeral Home

305 N. Potomac Street

Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. *Congestive Heart Failure*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*one week*

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Atherosclerotic Heart Disease*

Due to (or as a consequence of):

*unknown*

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D44996

29d. Date signed (Month, Day, Year)

Feb 14, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAPAR MAJIK 2021 Lappans Rd Baltimore MD 21713

31. Date filed (Month, Day, Year)

FEB 20 1997

32. Registrar's Signature

*[Signature]*State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06187

|  |   |   |  |  |   |  |   |   |
|--|---|---|--|--|---|--|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Shirley A. Olenchok</b>                                  |   |  |  | 2. Date of Death<br>Month Day Year<br><b>February 11 1997</b> |  | 3. Time of Death<br><b>0123</b>   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Union Hospital of Cecil County</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Elkton</b>         |  | 4c. County of Death<br><b>Cecil</b>   |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>171-26- 2991</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.   | If Under 1 Year<br>Months Days                                | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>January 28, 1934</b>                          | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b> |
|  | Usual Residence of Decedent   |   |  |  |   |  |   |   |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Cecil</b>   |  | 10c. City, Town or Location<br><b>Earleville</b>   |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>18 Summit Road</b>  |   |   |  | 10f. Zip Code<br><b>21919</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>  |   |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>self employed/owner</b>  |   | 16b. Kind of Business/Industry<br><b>country store</b>   |   |   |
| 17. Father's Name (First, Middle, Last)<br><b>George Reeder</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margurite Boyle</b>  |   |  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert G. Olenchok/Husband</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>18 Summit Road, Earleville, Maryland 21919</b>   |   |  |   |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lawn Croft Cemetery</b>  |  | Date<br><b>2/14/97</b>   |   | 20c. Location - City or Town, State<br><b>Linwood, Pennsylvania</b>  |   |   |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>Hicks Home for Funerals, P.A.<br/>103 West Stockton Street, Elkton, MD 21921</b>  |   |  |   |   |
| 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Septic Shock</b><br>Due to (or as a consequence of):<br>b. <b>Sepsis, unknown source</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |   |  |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Probable Myocardial Infarction</b><br><b>Abnormal Liver function</b><br><b>Alcohol abuse</b>  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |   |  |   |   |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred                               |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D30291</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>2/11/97</b>  |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>111 W. HIGH ST ST 204 ELKTON, MD 21921</b>  |   |   |  |  |   |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 13 1997</b>  |   | 32. Registrar's Signature<br>  |  |  |   |  |   |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Marguerite Joan Pensinger Certificate of Death

Reg. No.

97 06188

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Marguerite Joan Pensinger

2. Date of Death

Month  
FEBDay  
14Year  
97

3. Time of Death

5:00 PM

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

212-14-7000

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

March 19, 1919

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

157 S. Prospect Street

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

sales associate

16b. Kind of Business/Industry

retail

17. Father's Name (First, Middle, Last)

Thomas Joseph Mc Neal

18. Mother's Name (First, Middle, Maiden Surname)

Mamie Bell Elbon

19a. Informant's Name/Relationship (Type, Print)

John L. Pensinger

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11716 Galt Avenue Wheaton, Maryland 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rose Hill Cemetery

Date

2/19/97

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Gerald N. Minnich

22. Name and Address of Facility

Gerald N. Minnich  
Funeral Home305 N. Potomac Street  
Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Respiratory Failure

Due to (or as a consequence of):

b. Cerebral Infarction

Due to (or as a consequence of):

c. Cerebral Atherosclerosis

Due to (or as a consequence of):

d. Hypertension

Approximate Interval Between Onset and Death

5 minutes

28 hours

Years.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma of Right Lung

Pneumonia

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George E. Way, MD

29c. License number

D30757

29d. Date signed (Month, Day, Year)

02 14 97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

George E. Way, MD, 324 E Antietam St., Hagerstown, MD 21740

31. Date filed (Month, Day, Year)

FEB 19 1997

32. Registrar's Signature

John A. Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06189

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George Parker

2. Date of Death

February 15, 97

3. Time of Death

1312

4a. Facility Name (If not institution, give street and number)

Union Hospital

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

5. Social Security Number

248-50-3082

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Apr 10 1930

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

MD

10b. County

Cecil

10c. City, Town or Location

Rising Sun

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

340 Bard Cameron Rd

10f. Zip Code

21911

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Journey Lineman

16b. Kind of Business/Industry

Electric

17. Father's Name (First, Middle, Last)

Herbert Braxton Parker

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Eloise J. Parker/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

340 Bard Cameron Rd Rising Sun MD 21911

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

R A Ferris

Feb 21 1997

Date

20c. Location - City or Town, State

West Chester PA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

R. T. Foard Funeral Home, P.A.  
111 S Queen St. Rising Sun MD 2191123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Subarachnoid Hemorrhage  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

1 day

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Lastb. Hypertension  
Due to (or as a consequence of):

&gt; 1 year

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

044373

29d. Date signed (Month, Day, Year)

2/15/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph K. Weidner, Jr. MD

101 Colonial Way, Rising Sun MD 21911

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

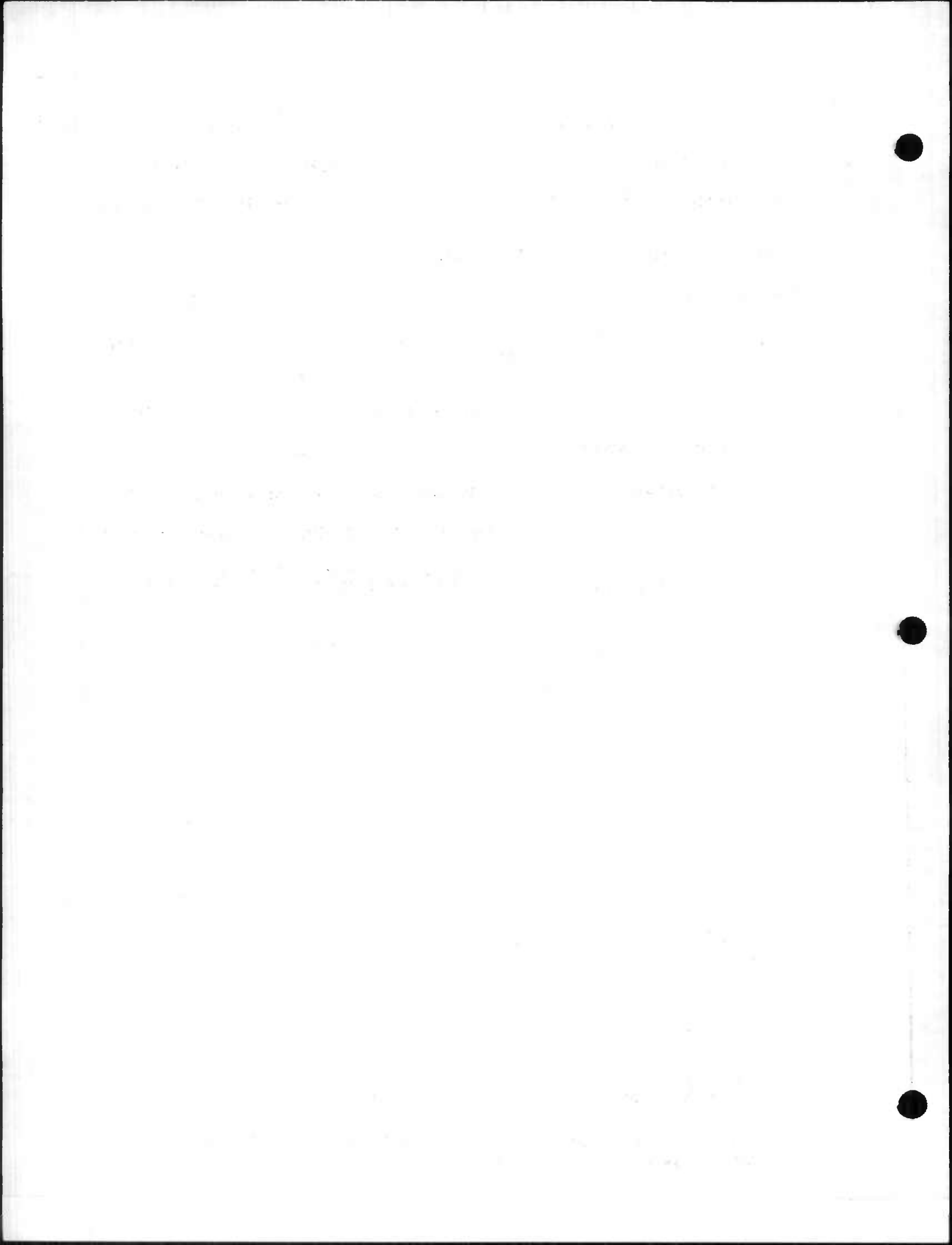
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





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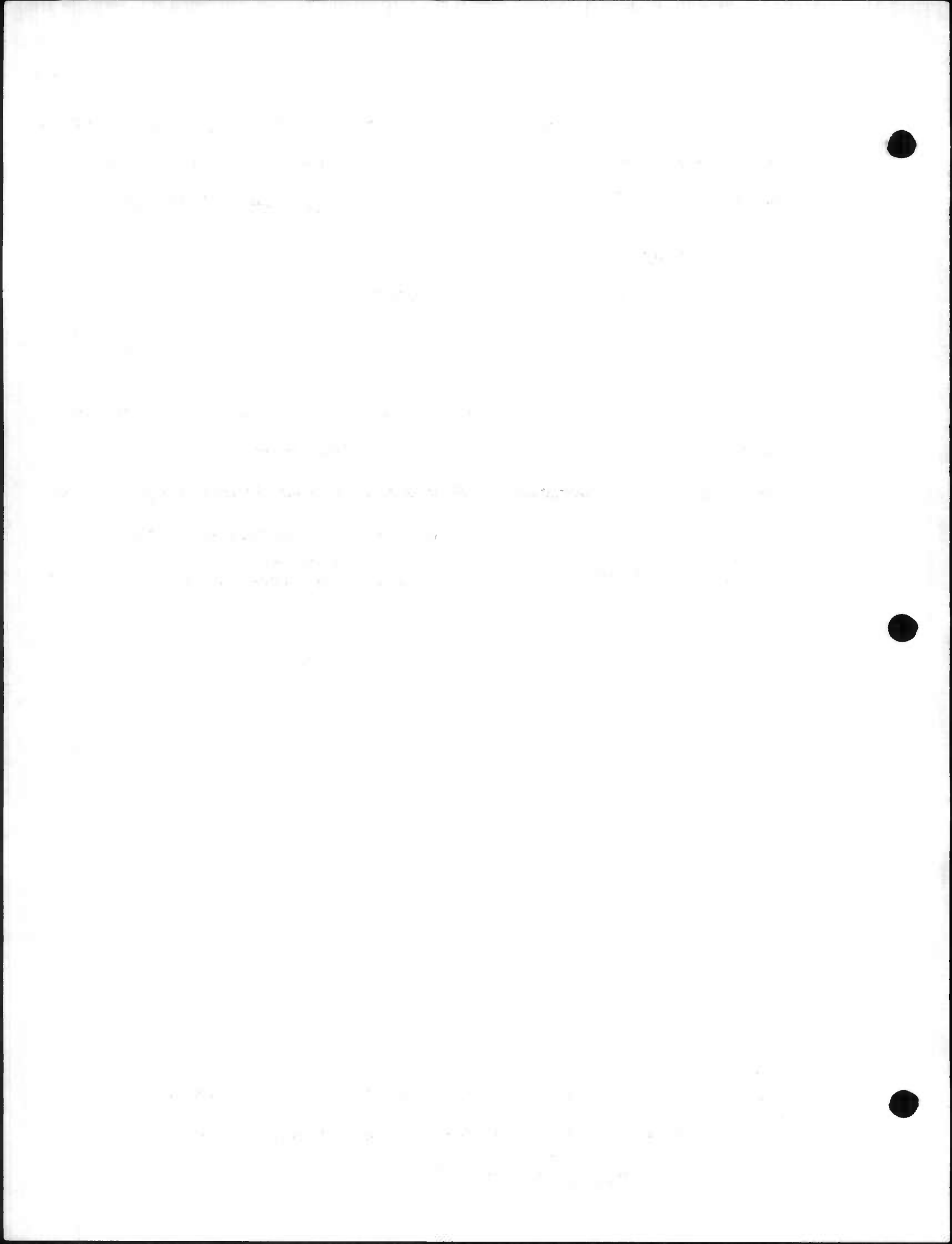
State of Maryland / Department of Health and Mental Hygiene

97 06190

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Mark Price</b>  |  | 2. Date of Death<br>Month <b>February</b> Day <b>08</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>9:20 pm</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>4960 Sentinel Drive</b>   |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>   |  | 4c. County of Death<br><b>Montgomery</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>282-03-7817</b>  | 6. Sex<br><b>1</b> M <b>2</b> F  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Jan 21, 1910</b> | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>  |
|   | Usual Residence of Decedent  |  |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>  | 10b. County<br><b>Montgomery</b>   | 10c. City, Town or Location<br><b>Bethesda</b>  |  | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No  |
|   | 10e. Street and Number<br><b>4960 Sentinel Drive</b>   |  | 10f. Zip Code<br><b>20816</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>                    |  | 16. Kind of Business/Industry<br><b>President of Building Devel. Council Industry</b>  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Mark Price</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sarah Moran</b>   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Pam Price daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8360 Greenboro Dr. #323, McLean, Virginia 22102</b> |  |  |
|   | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holy Trinity Cemetery</b>  |  | 20c. Date<br><b>2/14/97</b>  |
|   | 20d. Location - City or Town, State<br><b>Avon, Ohio</b>   |  | 21. Signature of Funeral Service Licensed<br>                         |  |  |
|   | 22. Name and Address of Facility<br><b>Donaldson Funeral Home, P.A.<br/>313 Talbott Ave. Laurel, Maryland 20707-4389</b>   |  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Ventricular Fibrillation</b><br>Due to (or as a consequence of):<br><b>Coronary Arteriosclerotic Disease</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. 1 Year</b><br><b>c. 5 Minutes</b><br><b>d.</b> |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Carcinoma, squamous cell of nasopharynx</b>  |  |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown   |  |  |   |  |  |
| 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No  |  |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No   |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |   |  |  |
| 27. Manner of Death<br><b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide <b>5</b> Pending investigation <b>6</b> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>                            |  |
| 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No  |  | 28d. Describe how Injury occurred  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D-11031</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>Feb 9, 1997</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Joseph Wallace, M.D. 5272 River Road, Bethesda, Maryland 20816</b>   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 10 1997</b>   |  | 32. Registrar's Signature<br>   |   |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06191

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MOZELLE IRENE PARRISH

2. Date of Death  
Month Day Year

February 11, 1997

3. Time of Death

9:15 AM

4a. Facility Name (If not institution, give street and number)

WATERVIEW HEALTHCARE CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

217-18-3440

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

September 4, 1915

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

105 Times Square

10f. Zip Code

21801

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sorter

16b. Kind of Business/Industry

Newspaper &amp; Magazine Co.

17. Father's Name (First, Middle, Last)

William E.

Sullivan

18. Mother's Name (First, Middle, Maiden Surname)

Lucy I. Seymore

19a. Informant's Name/Relationship (Type, Print)

Margaret I. Parrish/daughter-in-law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rt. 1, Box 100-A16, Bridgeville, De 19933

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cemetery 2/13/97 Baltimore, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

MO1051

22. Name and Address of Facility

Holloway Funeral Home

501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Acute atherothrombotic occlusion of left coronary artery

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Generalized atherosclerosis

Due to (or as a consequence of):

c. Diabetes, hyperlipidemia

Due to (or as a consequence of):

d. Long-standing hypertension

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

029349

29d. Date signed (Month, Day, Year)

2/11/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

John A. Davidson

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

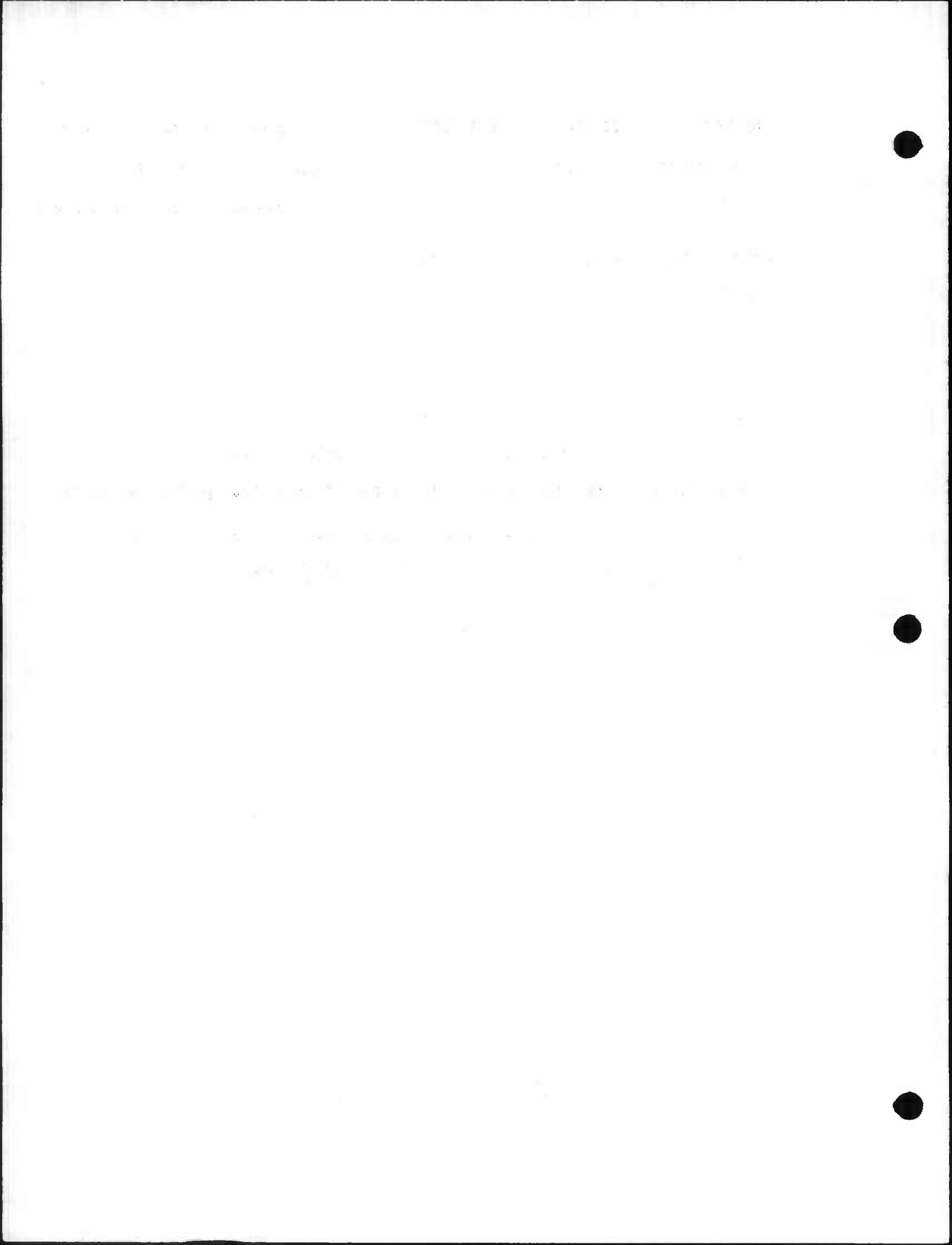
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06192

Reg. No.

|   |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner               | 1. Decedent's Name (First, Middle, Last)<br>MARGARET GOLDIE COTTMAN  |  |  | 2. Date of Death<br>Month Day Year<br>February 10 1997  |  |  | 3. Time of Death<br>1008   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>PENINSULA REGIONAL MEDICAL CENTER  |  |  | 4b. City, Town, or Location of Death<br>SALISBURY   |  |  | 4c. County of Death<br>WICOMICO  |  |  |
| Funeral<br>Director                             | 5. Social Security Number<br>212-14-4834   |  |  | 8. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  |  | 7. Age (in yrs. last birthday)<br>85 Yrs.  |  |  |
|   | Usual Residence of Decedent<br>10a. State MD. 10b. County WICOMICO 10c. City, Town or Location SALISBURY   |  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |  |
| To Be Completed by Funeral Director             | 10e. Street and Number<br>333 DELAWARE AVENUE  |  |  | 10f. Zip Code<br>21801  |  |  | 10g. Citizen of What Country?<br>USA   |  |  |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7th College (1-4or 5+)   |  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>DOMESTIC  |  |  | 16b. Kind of Business/Industry<br>RET. DAYCARE CENTER  |  |  |
| To Be Completed by Physician/Medical Examiner   | 17. Father's Name (First, Middle, Last)<br>GEORGE COTTMAN  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>GERTRUDE WHITNEY   |  |  | 19a. Informant's Name/Relationship (Type, Print)<br>MELVILLE T. POLK/ SON  |  |  |
|   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>28692 OCEAN GATEWAY, SALISBURY, MD. 21801   |  |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>FRIENDSHIP UM CH. CEM. 2-15  |  |  |
| Physician<br>/Medical<br>Examiner               | 21. Signature of Funeral Service Licensee<br><i>Loretta B. Jolley</i>  |  |  | 22. Name and Address of Facility<br>JOLLEY MEMORIAL CHAPEL<br>1213 JERSEY ROAD, SALISBURY, MD. 21801  |  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Cardiac arrest<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Coronary heart failure<br>Hypertension |  |  |
|   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  | 23c. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |
| To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |  |
|   | 28a. Date of Injury (Month, Day Year)  |  |  | 28b. Time of Injury<br>M  |  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |
| State<br>Registrar                              | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  |  | 29c. License number<br>029349  |  |  |
|   | 29d. Date signed (Month, Day, Year)<br>2/11/97   |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr William Robins 1104 HEATHWAY DRIVE Salisbury MD  |  |  | 31. Date filed (Month, Day, Year)<br>FEB 12 1997   |  |  |
| 32. Registrar's Signature<br><i>[Signature]</i> |  |  |  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

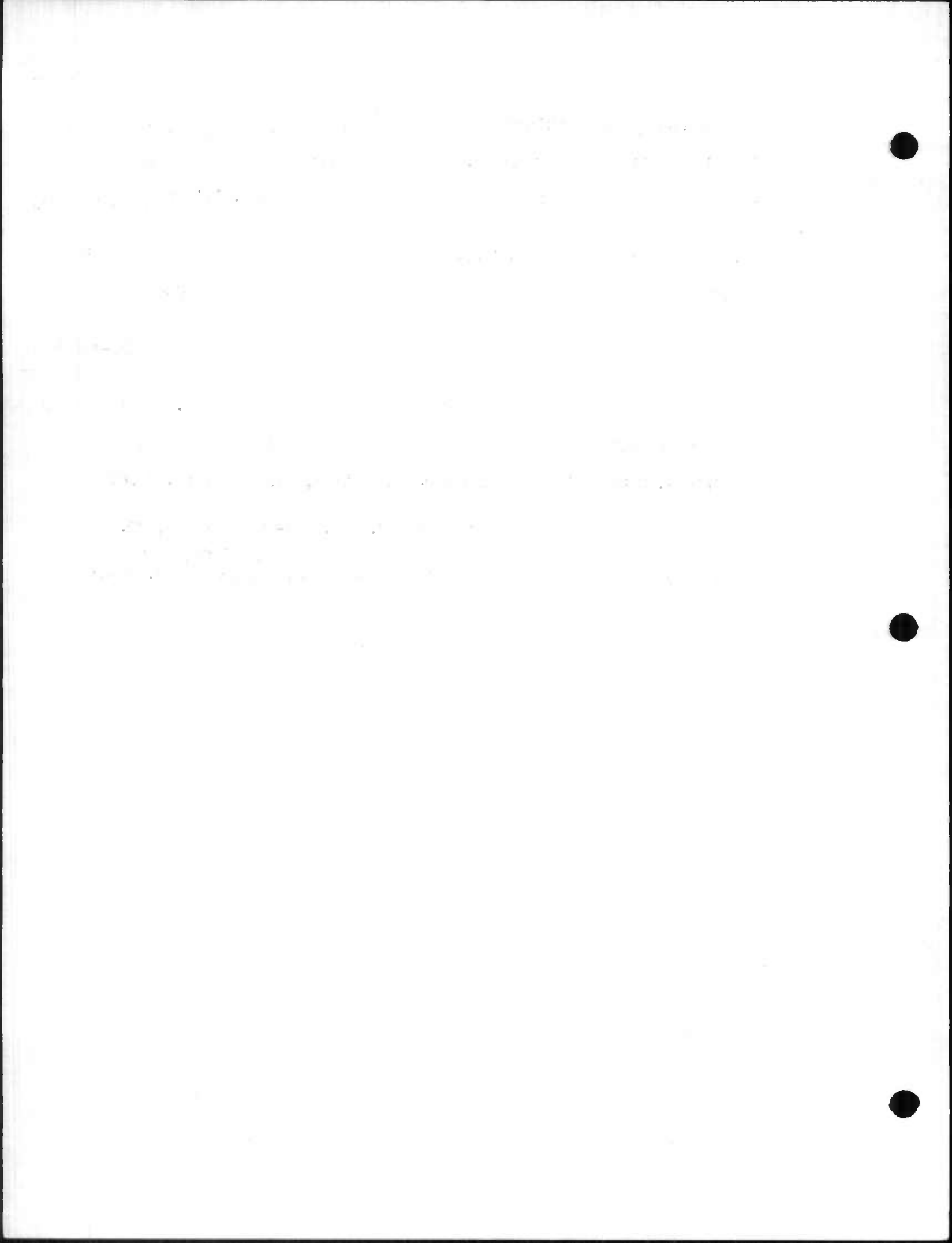
Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06193

Items: 23 part I, per physician G-745 3/18/97 <sup>reb</sup> Certificate of Death

Reg. No.

|  |  |                                       |   |  |   |   |  |  |  |
|--|--|---------------------------------------|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Louis JONA Rosenfield JR</b>  |                                       |   |  | 2. Date of Death<br>Month Day Year<br><b>February 14, 1997</b>  |   | 3. Time of Death<br><b>11:30 A.M.</b>  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>FREDERICK MEMORIAL HOSPITAL</b>   |                                       |   |  | 4b. City, Town, or Location of Death<br><b>FREDERICK</b>  |   | 4c. County of Death<br><b>FREDERICK</b>  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>312-05-5735</b>  |                                       | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.                             | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>JUL 24, 1915</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>TEXAS</b> |  |
|  | Usual Residence of Decedent  |                                       |   |  |   |   |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MARYLAND</b>  |                                       | 10b. County<br><b>CARROLL</b>   |  | 10c. City, Town or Location<br><b>KEYMAR</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
|  | 10e. Street and Number<br><b>700 FRANCIS SCOTT KEY HWY</b>   |                                       |   |  | 10f. Zip Code<br><b>21757</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |                                       |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SARGARENT</b>   |   | 16b. Kind of Business/Industry<br><b>US AIR FORCE</b>  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>LOUIS JONA ROSENFELD, SR</b>   |                                       |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FLORA THOMAS</b>  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>ELIZABETH ROSENFELD, WIFE</b>   |                                       |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>700 FRANCIS SCOTT KEY HWY, KEYMAR, MD 21757</b>   |   |  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CARROLL CREMATIONS</b>   |  | Data<br><b>2/16</b>   |   | 20c. Location - City or Town, State<br><b>HAMPSTEAD, MD</b>                                    |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Steven W. Eline</i>  |                                       |   |  | 22. Name and Address of Facility<br><b>ELINE FUNERAL HOME<br/>934 S MAIN ST, HAMPSTEAD, MD 21074</b>  |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Ischemic cardiomyopathy</b><br>Due to (or as a consequence of):<br>b. <b>congestive heart failure</b><br>Due to (or as a consequence of):<br>c. <b>renal failure</b><br>Due to (or as a consequence of):<br>d. <b>dementia</b> |                                       |   |  |   |   |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |                                       |   |  |   |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                                       |   |  |   |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                       |   |  |   |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                       |   |  |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                       |   |  |   |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |                                       |   |  |   |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year) |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                        |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |                                       |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                       |   |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br><i>Michael H. Ripkin, MD</i>  |  |                                       |   | 29c. License number<br><b>D43025</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>February 14, 1997</b>                             |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Michael H. Ripkin, MD, 801 Toll House Ave, HY, Frederick MD 21701</b>   |  |                                       |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 18 1997</b>  |  |                                       |   | 32. Registrar's Signature<br><i>John Andrew Randall</i>                      |   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06194

Item: 1 per MEO G-746 4/1/97 reb

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RAYMOND RAY WILLIAM ROSS

2. Date of Death

Month

Day

Year

FEB. 14, 1997 1800 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

26741 SILOAM ROAD

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

214-12-6865

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

06/01/1922

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WICOMICO

10c. City, Town or Location

SALISBURY

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

26741 SILOAM ROAD

10f. Zip Code

21801

10g. Citizen of What Country?

U.S.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HEAVY EQUIPMENT OPERATOR

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

WILLIAM ZADOK ROSS

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE MAY BUTLER

19a. Informant's Name/Relationship (Type, Print)

MARGARET BEAUCHAMP/SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

33743 DUBLIN ROAD, PRINCESS ANNE, MD. 21853

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

BEECHWOOD CEMETERY

Date

02/18/97 PRINCESS ANNE, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HINMAN FUNERAL HOME

11673 SOMERSET AVE., PRINCESS ANNE, MD. 21853

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Intracranial gunshot wound of head

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOAOther: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural☐ Accident☒ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

2-14-97

28b. Time of Injury

(Month, Day, Year)

Found 1600

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

Subject shot self

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

home, in bed

28f. Location (Street and Number or Rural Route Number,

City or Town, State) 26741 Siloam Road

Salisbury, Wicomico, MD

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☒ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Donald G. Wright MD

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

FEB. 15, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 19 1997

32. Registrar's Signature

John D. Wright

Baltimore, Maryland 21215-0020

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06195

## Certificate of Death

Reg. No.

|  |  |                               |   |   |  |  |  |   |   |  |
|--|--|-------------------------------|---|---|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Elma Ruth Shaeffer</b>                                    |                               |   |   | 2. Date of Death<br>Month <b>Feb.</b> Day <b>14</b> Year <b>1997</b>   |  |  |   | 3. Time of Death<br><b>approx 3:00 AM</b>                   |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>Carroll County General Hospital</b> |                               |   |   | 4b. City, Town, or Location of Death<br><b>Westminster</b>   |  |  |   | 4c. County of Death<br><b>Carroll</b>                       |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-01-8614</b>  |                               | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>July 18, 1908</b>                      |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
|  | Usual Residence of Decedent  |                               |   |   |  |  |  |   |   |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Carroll</b> |   | 10c. City, Town or Location<br><b>Westminster</b>   |  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
| 10e. Street and Number<br><b>205 St. Mark Way, Apt. 315</b>  |  |                               |   | 10f. Zip Code<br><b>21158</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)   |  |                               |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b> |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>                                |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Harry Myers</b>  |  |                               |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Clara Lawyer</b>   |  |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Yvonne Mathias, daughter</b>  |  |                               |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1811 Shawan Valley Lane, Reisterstown, MD 21136-5723</b>                                 |  |  |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Krider's Church Cemetery</b>   |   |  | 20c. Location - City or Town, State<br><b>Westminster, MD</b>  |  |   |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Katherine Little - Switzer</b>   |  |                               |   |   | 22. Name and Address of Facility<br><b>Westminster Funeral Home &amp; Chapel<br/>412 Washington Rd., Westminster, MD 21157</b>   |  |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. <b>Abdominal aortic aneurysm</b> / week<br>Due to (or as a consequence of):<br>b. <b>renal failure</b><br>Due to (or as a consequence of):<br>c. <b>pulmonary failure</b><br>Due to (or as a consequence of):<br>d. <b>sepsis</b><br><br>Approximate Interval Between Onset and Death<br><b>5 days</b><br><b>4 days</b> |  |                               |   |   |  |  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                               |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |   |  |
|  |  |                               |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                               | 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  |                               | 28e. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | 28d. Describe how injury occurred                           |  |
|  |  |                               | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |                               |   |   |  |  |  |   |   |  |
| 29b. Signature and title of certifier<br><b>John A. Steur MD</b>   |  |                               | 29c. License number<br><b>MD D44614</b>   |   |  | 29d. Date signed (Month, Day, Year)<br><b>2/17/97</b>  |  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>285 Stoner Ave Westminster MD 21157</b>   |  |                               |   |   |  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 18 1997</b>  |  |                               | 32. Registrar's Signature<br><b>John A. Steur</b>   |   |  |  |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06196

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RUTH IRENE SMITH

2. Date of Death

Feb 14 1997

3. Time of Death

0400 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

220-86-9029

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

February 8, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Boonsboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6534 Old National Pike

10f. Zip Code

21713

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8 Years

College (14 or 5+)

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Personal Residence

17. Father's Name (First, Middle, Last)

Otis R. Rowland

18. Mother's Name (First, Middle, Maiden Surname)

Esther Long

19a. Informant's Name/Relationship (Type, Print)

Patricia Young, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

630 Summit Avenue, Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Boonsboro Cemetery 02/17/97

Date

20c. Location - City or Town, State

Boonsboro, Maryland

21. Signature of Funeral Service Licensee

P. Steven Danfelt, Jr. M01093

22. Name and Address of Facility

7606 Old National Pike  
BAST FUNERAL HOME Boonsboro, Maryland 21713

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

b. Metastatic Breast Cancer

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

One week

One year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation  
Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

P. Steven Danfelt, Jr.

29c. License number

D44996

29d. Date signed (Month, Day, Year)

Feb 14, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ZAFAR MALIK MD 20311 LAPPONS RD BOONSBORO MD 21713

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

John Anderson-Ricketts

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06197

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Lloyd Calvin Shumaker

2. Date of Death

Month  
Feb

Day

Year  
1997

3. Time of Death

15:30

4a. Facility Name (If not institution, give street and number)

WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death

HAGERSTOWN

4c. County of Death

WASHINGTON

5. Social Security Number

217-01-6121

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month, Day, Year  
Oct. 1, 1918

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

Washington

10c. City, Town or Location

Smithsburg

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

21809 Auburn Dr.

10f. Zip Code

21783

10g. Citizen of What Country?

U.S.A

11. Marital Status

☐ Never Married☒ Married☐ Widowed☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: 41-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Roofing Co.

17. Father's Name (First, Middle, Last)

Jacob Franklin Shumaker

18. Mother's Name (First, Middle, Maiden Surname)

Tessie Florence Mundy

19a. Informant's Name/Relationship (Type, Print)

Margaret E. Shumaker (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21809 Auburn Dr. Smithsburg, Md. 21783

20a. Method of Disposition

☒ Burial☐ Cremation☐ Removal from State☐ Donation☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rocky Gap Veterans Cem. Feb. 21, 97

Date

20c. Location - City or Town, State

Flintstone, Md.

21. Signature of Funeral Service Licensee

Dennis R. Davis

22. Name and Address of Facility

Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. VENTRICULAR FIBRILLATION

Due to (or as a consequence of):

Approximate interval between Onset and Death

30'

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

40'

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

CONGESTIVE HEART FAILURE

MYOCARDIAL INFARCTION

23b. Did tobacco use contribute to the cause of death?

☐ Yes☐ No☐ Probably☐ Unknown

24a. Was an autopsy performed?

☐ Yes☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes☒ No

25. Was case referred to medical examiner?

☐ Yes☒ No

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Physician☐ Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Lloyd Calvin Shumaker MD

29c. License number

P416622

29d. Date signed (Month, Day, Year)

FEB 17 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ERNEST WITKAMP MD 19236 MEADOW VIEW DR HAGERSTOWN MD

31. Date filed (Month, Day, Year)

FEB 2 0 1997

32. Registrar's Signature

John A. Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





97 06198

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>HENRIETTA ESTELLE STALLKNECHT  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 17, 1997   |  | 3. TIME OF DEATH<br>6:05 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>213-05-6785   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>89 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Sept. 7, 1907                              |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Fahrney-Keedy Memorial Home  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Boonsboro  |  | 9c. COUNTY OF DEATH<br>Washington  |  |
| 10a. STATE<br>Maryland   |  |  |  | 10b. COUNTY<br>Washington   |  | 10c. CITY, TOWN OR LOCATION<br>Boonsboro   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>8507 Mapleville Road   |  |  |  | 10f. ZIP CODE<br>21713  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>homemaker   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>home  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Harry G. Roebuck  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Henrietta Johanna Dubblede   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>R. Allard Stallknecht  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8507 Mapleville Road Boonsboro, Maryland 21713   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Parkwood Cemetery   |  | DATE<br>2/21/97   |  | 20c. LOCATION — City or Town, State<br>Baltimore, Maryland                           |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Gerald N. Minnich</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Gerald N. Minnich 305 N. Potomac Street<br>Funeral Home Hagerstown, Maryland  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |   |  |  |  |
| a. Left Hemisphere Cerebral Vascular Accident (Brain Attack) 2 months  |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| b. Arteriosclerotic Heart Disease  |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| c.   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| d.   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Diabetes Mellitus Type I   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Edward W. Ditto, III</i>   |  |  |  | 29c. LICENSE NUMBER<br>D01062   |  | 29d. DATE SIGNED (Month, Day, Year)<br>February 18, 1997                             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Edward W. Ditto, III, M.D. 217 W. Washington St. Hagerstown, Md 21740   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 20 1997   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Harrison</i>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06199

|  |   |   |   |  |  |  |  |  |   |  |                 |   |    |   |    |  |    |                                   |  |  |  |  |  |
|--|---|---|---|--|--|--|--|--|---|--|-----------------|---|----|---|----|--|----|-----------------------------------|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Isabel Margaret Stauffer  |   |   |  | 2. Date of Death<br>Month Day Year<br>February 9, 1997   |  | 3. Time of Death<br>9:04 a.m.                                    |  |   |  |                 |   |    |   |    |  |    |                                   |  |  |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Residence: 49 Maple Hill Drive  |   |   |  | 4b. City, Town, or Location of Death<br>Port Deposit   |  | 4c. County of Death<br>Cecil                                     |  |   |  |                 |   |    |   |    |  |    |                                   |  |  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>215-34-0709  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>79 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Jan. 25, 1918             |  |   |  |                 |   |    |   |    |  |    |                                   |  |  |  |  |  |
|  | 9. Birthplace (State or Foreign Country)<br>Maryland  |   | 10a. State<br>Maryland  |  | 10b. County<br>Cecil   |  | 10c. City, Town or Location<br>Port Deposit                      |  |   |  |                 |   |    |   |    |  |    |                                   |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br>49 Maple Hill Drive   |  | 10f. Zip Code<br>21904   |  | 10g. Citizen of What Country?<br>U.S.A.                          |  |   |  |                 |   |    |   |    |  |    |                                   |  |  |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |   |  |                 |   |    |   |    |  |    |                                   |  |  |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>Twelve Years  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                |  | 16b. Kind of Business/Industry<br>Personal Residence   |  |  |  |   |  |                 |   |    |   |    |  |    |                                   |  |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>John Coulson   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Myrtle Wiggins  |  |  |  |   |  |                 |   |    |   |    |  |    |                                   |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Beverly A. Chapman (Niece)  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>119 Hollingsworth Manor, Elkton, Maryland 21921   |  |  |  |   |  |                 |   |    |   |    |  |    |                                   |  |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>R.A. Ferris & Company   |  | 20c. Location - City or Town, State<br>West Chester, Pennsylvania  |  | 20d. Date<br>2/10/97   |  |   |  |                 |   |    |   |    |  |    |                                   |  |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>Thomas M. Patterson, Sr.   |   |   |  | 22. Name and Address of Facility<br>Lee A. Patterson & Son Funeral Home<br>Perryville, Maryland 21903-0188   |  |  |  |   |  |                 |   |    |   |    |  |    |                                   |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |  |  |  |   |  |                 |   |    |   |    |  |    |                                   |  |  |  |  |  |
|  | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Brain Hemiation</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td>metastatic lung cancer</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |   |   |  |  |  |  |  | Immediate Cause (Final disease or condition resulting in death) | a.                                     | Brain Hemiation | Approximate Interval Between Onset and Death  | b. | metastatic lung cancer  | c. |  | d. |                                   |  |  |  |  |  |
|  | Immediate Cause (Final disease or condition resulting in death)   | a.  | Brain Hemiation   | Approximate Interval Between Onset and Death   |  |  |  |  |   |  |                 |   |    |   |    |  |    |                                   |  |  |  |  |  |
| b.   |   | metastatic lung cancer  |   |  |  |  |  |  |   |  |                 |   |    |   |    |  |    |                                   |  |  |  |  |  |
| c.   |   |   |   |  |  |  |  |  |   |  |                 |   |    |   |    |  |    |                                   |  |  |  |  |  |
| d.   |   |   |   |  |  |  |  |  |   |  |                 |   |    |   |    |  |    |                                   |  |  |  |  |  |
| <table border="1"> <tr> <td colspan="4">23b. Did tobacco use contribute to the cause of death?<br/>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="2">24a. Was an autopsy performed?<br/>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="2">24b. Were autopsy findings available prior to completion of cause of death?<br/>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> </table>   |   |   |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |  |                 | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |    | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |    |  |    |                                   |  |  |  |  |  |
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| <table border="1"> <tr> <td colspan="4">25. Was case referred to medical examiner?<br/>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> </tr> <tr> <td colspan="4">26. Place of Death (Check only one)<br/>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</td> </tr> </table>  |   |   |   |  |  |  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |                 | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |    |   |    |  |    |                                   |  |  |  |  |  |
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| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |   |   |   |  |  |  |  |  |   |  |                 |   |    |   |    |  |    |                                   |  |  |  |  |  |
| <table border="1"> <tr> <td colspan="2">27. Manner of Death<br/>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br/>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</td> <td colspan="2">28a. Date of Injury (Month, Day, Year)</td> <td colspan="2">28b. Time of Injury<br/>M</td> <td colspan="2">28c. Injury at Work?<br/>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> <tr> <td colspan="2"></td> <td colspan="2">28d. Describe how injury occurred</td> <td colspan="2">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="2">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table> |   |   |   |  |  |  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year) |                 | 28b. Time of Injury<br>M  |    | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |    |  |    | 28d. Describe how injury occurred |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |
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| <table border="1"> <tr> <td colspan="4">29a. Certifier (Check only one)<br/>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</td> </tr> <tr> <td colspan="2">29b. Signature and title of certifier<br/>L. Kidani-Ryan MD</td> <td colspan="2">29c. License number<br/>D46467</td> <td colspan="2">29d. Date signed (Month, Day, Year)<br/>2/10/97</td> </tr> </table>  |   |   |   |  |  |  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |                 | 29b. Signature and title of certifier<br>L. Kidani-Ryan MD  |    | 29c. License number<br>D46467   |    | 29d. Date signed (Month, Day, Year)<br>2/10/97 |    |                                   |  |  |  |  |  |
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| 29b. Signature and title of certifier<br>L. Kidani-Ryan MD   |   | 29c. License number<br>D46467   |   | 29d. Date signed (Month, Day, Year)<br>2/10/97   |  |  |  |  |   |  |                 |   |    |   |    |  |    |                                   |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>L. Kidani-Ryan 101 Coloma Way Rising Sun Md 21911  |   |   |   |  |  |  |  |  |   |  |                 |   |    |   |    |  |    |                                   |  |  |  |  |  |
| <table border="1"> <tr> <td colspan="4">31. Date filed (Month, Day, Year)<br/>FEB 12 1997</td> <td colspan="4">32. Registrar's Signature<br/>John Davidson-Randall</td> </tr> </table>   |   |   |   |  |  |  |  | 31. Date filed (Month, Day, Year)<br>FEB 12 1997   |   |  |                 | 32. Registrar's Signature<br>John Davidson-Randall  |    |   |    |  |    |                                   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 12 1997   |   |   |   | 32. Registrar's Signature<br>John Davidson-Randall                                     |  |  |  |  |   |  |                 |   |    |   |    |  |    |                                   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06200

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RONALD SELNER SR.

2. Date of Death

Month Day Year  
FEBRUARY 19, 1997

3. Time of Death

06:45 AM  
FOUND

4a. Facility Name (If not institution, give street and number)

10511 BRANDYWINE ROAD

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

578-46-8624

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 25, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Clinton

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

10511 Brandywine Road

10f. Zip Code

20735

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
9th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Alexander Hunter Sellner

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Parates

19a. Informant's Name/Relationship (Type, Print)

Geraldine Sellner

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10511 Brandywine Road, Clinton, Maryland 20735

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Trinity Memorial Gardens

Feb 22, 1997

20c. Location - City or Town, State

Waldorf, Maryland

21. Signature of Funeral Service Licensee

Sh S. Sittler

22. Name and Address of Facility

Lee Funeral Home, Inc 6633 Old  
Alexandria Ferry Road, Clinton, Maryland 2073523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. HANGING

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?  
☒ Yes ☐ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

28. Place of Death (Check only one)

Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☒ Suicidal ☐ Homicide

28a. Date of Injury

(Month, Day, Year)  
FEB. 19, 1997

28b. Time of Injury

06:45 AM  
FOUND

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

SUBJECT HANGED SELF

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

HOME

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

10511 BRANDYWINE RD CLINTON M.D.

29a. Certifier  
(Check only  
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

PERMITS MEDICAL EXAMINER  
D 33954

29d. Date signed (Month, Day, Year)

FEBRUARY 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARK F. GOLLE JR. M.D. 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 20 1997

32. Registrar's Signature

John Davidson Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
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completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06201

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert A. Shaffer Sr.

2. Date of Death

Month 2 Day 13 Year 97

3. Time of Death

05:14

4a. Facility Name (If not institution, give street and number)

R.A. Cowley Shock Trauma Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

None

Funeral  
Director

5. Social Security Number

215-34-1547

6. Sex

M

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) June 21, 1936

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6411 Hickory Lane

10f. Zip Code

21784

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Engineering Technician

16b. Kind of Business/Industry

Television

17. Father's Name (First, Middle, Last)

Alvin D. Shaffer

18. Mother's Name (First, Middle, Maiden Surname)

Mary Appel

19a. Informant's Name/Relationship (Type, Print)

Constance D. Shaffer/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6411 Hickory Lane Sykesville, Maryland 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crest Lawn Memorial Cem.

Date

2-17-97

20c. Location - City or Town, State

Marriottsville, MD

21. Signature of Funeral Service Licensee

Harry H. Witzke

22. Name and Address of Facility

Harry H. Witzke Funeral Home, Inc.

4112 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Massive Traumatic Brain Injury

Due to (or as a consequence of):

b. Motor Vehicle Collision

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 day

3 day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

none

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☒ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

2/9/97

28b. Time of Injury

9:00 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Motor Vehicle Accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Liberty Rd

29a. Certifier (Check only one)

1 ☒ Physician 2 ☐ Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

H. Neal Reynolds MD

29c. License number

(MD) D27163

29d. Date signed (Month, Day, Year)

2/13/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. Neal Reynolds, 96 R.A. Cowley Shock Trauma Center, Baltimore, Md

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

John Davidson Carroll

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

8





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06202

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARTIN

EDWARD

SHORES

2. Date of Death

Month

Day

Year

FEBRUARY 17, 1997

3. Time of Death

0200

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

178-18-9019

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

07/12/1921

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MD

10b. County

SOMERSET

10c. City, Town or Location

CHANCE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

23425 DEAL ISLAND ROAD

10f. Zip Code

21816

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MANAGER

16b. Kind of Business/Industry

GAS STATION

17. Father's Name (First, Middle, Last)

EDDIE SHORES

18. Mother's Name (First, Middle, Maiden Surname)

EDITH LASKER

19a. Informant's Name/Relationship (Type, Print)

DARLENE WEBSTER/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12062 JEFFREY LANE, PRINCESS ANNE, MD. 21853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. PAULS CEMETERY

Date

02/19

20c. Location - City or Town, State

WENONA, MD.

21. Signature of Funeral Service Licensee

*[Signature]* M00295

22. Name and Address of Facility

HINMAN FUNERAL HOME  
11673 SOMERSET AVENUE, PRINCESS ANNE, MD. 21853

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Multi organ failure

Due to (or as a consequence of):

b.

Acute anterior MI &amp; Pulm arrest

Due to (or as a consequence of):

c.

Coronary artery disease

Due to (or as a consequence of):

d.

Atherosclerosis

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes, Stroke, aortic aneurysm

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D17181

29d. Date signed (Month, Day, Year)

2/17/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Bal Agarwal 614C Eastern Shore Drive, Salisbury Md. 21801

31. Date filed (Month, Day, Year)

FEB 19 1997

32. Registrar's Signature

*[Signature]*State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06203

## Certificate of Death

Reg. No.

|  |   |   |   |  |  |  |  |                                   |  |
|--|---|---|---|--|--|--|--|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Nina O. Sutton  |   |   |  | 2. Date of Death<br>Month Day Year<br>February 13, 1997  |  | 3. Time of Death<br>8:17 p.m.  |                                   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Edw.W.McCready Memorial Hospital  |   |   |  | 4b. City, Town, or Location of Death<br>Crisfield  |  | 4c. County of Death<br>Somerset  |                                   |  |
| Funeral<br>Director  | 5. Social Security Number<br>111-12-3313  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>86 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br>11-03-1910   | 9. Birthplace (State or Foreign Country)<br>MD   |                                   |  |
|  | Usual Residence of Decedent   |   |   |  |  |  |  |                                   |  |
| To Be Completed by Funeral Director  | 10e. State<br>MD  |   | 10f. County<br>Somerset   |  | 10g. City, Town or Location<br>Crisfield   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                   |  |
|  | 10e. Street and Number<br>5th + Broadway  |   |   |  | 10f. Zip Code<br>21817   |  | 10g. Citizen of What Country?<br>U.S.  |                                   |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                   |                                   |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary (Secondary) (0-12) 10th  |   | College (1-4or 5+)  |  | 16. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Laborer   |  | 16b. Kind of Business/Industry<br>Seafood  |                                   |  |
|  | 17. Father's Name (First, Middle, Last)<br>Archie Sutton  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>ETTA Sutton   |  |  |                                   |  |
| To Be Completed by Physician/Medical Examiner  | 19e. Informant's Name/Relationship (Type, Print)<br>Bobby White / Cousin  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>39691 DEALS Island RD Princess Anne, MD 21853   |  |  |                                   |  |
|  | 20e. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Asbury Cemetery   |  | Date<br>2-18-97  |  | 20c. Location - City or Town, State<br>Lawsonia, MD  |                                   |  |
|  | 21. Signature of Funeral Service Licensee<br>Anthony E. Ward  |   |   |  | 22. Name and Address of Facility<br>Anthony E. Ward Funeral Home<br>314 COVE ST. Crisfield, MD 21817   |  |  |                                   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |  |  |                                   |  |
|  | Immediate Cause (Final disease or condition resulting in death)<br>Pancreatic Abscess with Sepsis<br>Due to (or as a consequence of):<br>a. _____<br>b. _____<br>c. _____<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |  |  |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |                                   |  |
|  |   |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                                   |  |
|  |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |                                   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |                                   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |                                   |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |  |  |  |                                   |  |
| 29b. Signature and title of certifier<br>[Signature]   |   |   |   | 29c. License number<br>D 48098   |  | 29d. Date signed (Month, Day, Year)<br>2-13-1997   |  |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Dr. Vijay Karumbunathan, McCready Hospital, Crisfield, Md. 21817   |   |   |   |  |  |  |  |                                   |  |
| 31. Date filed (Month, Day, Year)<br>FEB 18 1997   |   |   |   | 32. Registrar's Signature<br>[Signature]                                     |  |  |  |                                   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06204

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Annie Mae Smullen

2. Date of Death

February 14, 1997 4:45PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Memorial Hospital @ Easton

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

215-38-2420

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 17 1943

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

28664 Ocean Gateway

10f. Zip Code

21801

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Benjamin McBride

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Jones

19a. Informant's Name/Relationship (Type, Print)

Warren Smullen (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

28664 Ocean Gateway Salisbury, Md. 21801

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Springhill Mem. Gardens

Date

2/12

20c. Location - City or Town, State

Hebron, Md.

21. Signature of Funeral Service Licensee

Gladys B. Stewart

22. Name and Address of Facility

Stewart Funeral Home  
821 West Rd. Salisbury, Md. 2180123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Hemorrhagic Basal Ganglia Stroke

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

Years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

pneumonia (Aspiration)

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Michael Lees

29c. License number

D42005

29d. Date signed (Month, Day, Year)

2/14/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL LEES M.D.

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Shirley A. Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



97 06205

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Chauncey Seldon</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb. 12 1997</b>   |  | 3. TIME OF DEATH<br><b>M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>225-46-7682</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>61</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov. 22 1935</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>8164 Jersey Road</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Salisbury</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Wicomico</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Wicomico</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Salisbury</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>8164 Jersey Road</b>  |  |
| 10f. ZIP CODE<br><b>21801</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>College</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Laborer</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>None</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Raymond Seldon</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Velsor Waters</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Michelle McDaniel</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8164 Jersey Rd. Salisbury, Md. 21801</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Salisbury Crematory</b>  |  | 20c. LOCATION — City or Town, State<br><b>Salisbury, Md.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Bladys B. Stewart</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Stewart Funeral Home<br/>821 West Rd. Salisbury, Md. 21801</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CORONARY ARTERY DISEASE</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>YEARS</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  |  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dr. Rene Desmarais</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D38353</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/17/97</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Rene Desmarais 560 Riverside Dr. Salisbury, MD</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 18 1997</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06206

## Certificate of Death

Reg. No.

|   |   |  |   |   |  |
|---|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ALFRED N. Smith</b>  |  | 2. Date of Death<br>Month <b>February</b> Day <b>10</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>1800</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>  |  | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>  |   | 4c. County of Death<br><b>WICOMICO</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>215-44-6900</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>49</b> Yrs.  | If Under 1 Year<br>Months Days                        | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>10-2-47</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>BERLIN, MD.</b>  |   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  |   |   |  |
|   | 10a. State<br><b>MD.</b>  | 10b. County<br><b>WORCESTER</b>  | 10c. City, Town or Location<br><b>BERLIN</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>10402 GRIFFIN ROAD,</b>  |  | 10f. Zip Code<br><b>21811</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LABORER</b>                       |   | 16b. Kind of Business/Industry<br><b>SELF-EMPLOYED</b>   |
|   | 17. Father's Name (First, Middle, Last)<br><b>UNKNOWN</b>   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>JENNIE SMITH</b>  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>MARGARET BAKER</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. BOX 424; BERLIN, MD. 21811</b>           |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ST. PAUL UM CHURCH CEM.</b>  |   | 20c. Location - City or Town, State<br><b>BERLIN, MD.</b>  |
|   | 21. Signature of Funeral Service Licensee<br><i>Patricia A. Jolley</i>  |  | 22. Name and Address of Facility<br><b>JOLLEY MEMORIAL CHAPEL,<br/>1213 Jersey Road - Salisbury, MD 21801</b>                                     |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>End Stage AIDS</b>    |  |   |   |  |
| 23b. Dld tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>                       |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   | 28d. Describe how Injury occurred  |   |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |   |  |
| 29b. Signature and title of certifier<br><i>Chris Snyder D.O.</i>   |   | 29c. License number<br><b>H50497</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>2/10/97</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Chris Snyder D.O. 108 Pine Bluff Rd. Salisbury, MD 21801</b>   |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 13 1997</b>   |   | 32. Registrar's Signature<br><i>John Davidson Randall</i>                    |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



97 06207

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ALMA CECILIA TAYLOR</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>14</b> YEAR <b>1997</b>  |  | 3. TIME OF DEATH<br><b>0555A.M.</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>011-12-6948</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>91</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>AUG 8, 1905</b>  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MASS.</b>   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>WESTMINSTER NURSING CENTER</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>WESTMINSTER</b>  |  | 9c. COUNTY OF DEATH<br><b>CARROLL</b>  |   |
| 10a. STATE<br><b>MD</b>  |  |  |  | 10b. COUNTY<br><b>CARROLL</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>WESTMINSTER</b>  |   |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>1234 WASHINGTON RD.</b>   |  | 10f. ZIP CODE<br><b>21157</b>  |   |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>D</b>        |   |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>MANAGER</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>APARTMENT COMPLEXES</b>   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>LOMAR MICHAEL LaHaie</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CORA ALICE DENAULT</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ROBERT A. TAYLOR</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2888 ARTERS MILL RD WESTMINSTER, MD 21158</b>                              |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>FAIRFAX MEMORIAL PARK</b>   |  | 20c. LOCATION — City or Town, State<br><b>FAIRFAX, VA.</b>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert A. Myers</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>91 Willis St WESTMINSTER, MD 21157</b>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Alzheimer's disease</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>2 YRS</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>cardiovascular disease</b>  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Salvatore J. [Signature] MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D01079</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/14/97</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 18 1997</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John [Signature] Randall</b>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06208

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET S TRAVERS

2. Date of Death

Month Day Year  
FEB 12 97

3. Time of Death

0719A

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

216-82-8459

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
6/21/1911

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

501 Rockford Rd.

10f. Zip Code

20902

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

2

18a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

House Wife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Gordon Stewart

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Carey

19a. Informant's Name/Relationship (Type, Print)

W. Wayne Travers

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

501 Rockford Road, Silver Spring 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Turners Cemetery

Date

2/16

20c. Location - City or Town, State

Nanticoke, Md.

21. Signature of Funeral Service Licensee

M00-417  
Cornelius B. [Signature]

22. Name and Address of Facility

Messick Funeral Home, P.O. Box 61  
Bivalve, Md. 2181423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

10 DAYS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SPLENIC HEMATOMA

FRACTURE T11

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☒ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)  
FEB 2 9728b. Time of  
injury

P M

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

FALL

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

HOME

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

H 10

29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D07099

29d. Date signed (Month, Day, Year)

FEB 12 97

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

FRANCIS C. MAYKO 1025 FERNWOOD RD BETHESDA MD 20817

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Julia [Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06209

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RALPH CHARLES

2. Date of Death

Tarr SR. February 12, 1997

3. Time of Death

0546

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

219-05-3600

6. Sex

M ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

August 31, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Fruitland

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

619 S. Camden Ave.

10f. Zip Code

21826

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
6

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Master Plumber

16b. Kind of Business/Industry

Plumbing

17. Father's Name (First, Middle, Last)

Charles Clayton Tarr

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Florence Smullen

19a. Informant's Name/Relationship (Type, Print)

Dorothy E. Tarr/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

619 S. Camden Ave., Fruitland, MD 21826

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Springhill Memory Gardens

Date

2/15/97

20c. Location - City or Town, State

Hebron, MD

21. Signature of Funeral Service Licensee

David H. Thompson MD1051

22. Name and Address of Facility

Holloway Funeral Home  
501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cardiac arrest

Due to (or as a consequence of):

b. Ischemic cardiomyopathy

Due to (or as a consequence of):

c. Atherosclerotic heart disease

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Clayton Rook MD

29c. License number

19289

29d. Date signed (Month, Day, Year)

1/13/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Clayton Rook MD PO Box 2636 Salisbury MD 21801

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06210

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |   |  |  |  |  |
|--|--|--|---|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>JOYCE N. THORNTON  |  |   |  | 2. Date of Death<br>Month Day Year<br>Feb. 8 1997  |   |  |  | 3. Time of Death<br>2:50 AM  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Salisbury Center Genesis ElderCare   |  |   |  | 4b. City, Town, or Location of Death<br>Salisbury, Md.   |   |  |  | 4c. County of Death<br>Wicomico  |  |
| Funeral<br>Director  | 5. Social Security Number<br>102-22-7523   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>69 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>DEC 15, 1927                                  |  | 9. Birthplace (State or Foreign Country)<br>PENNSYLVANIA   |  |
|  | Usual Residence of Decedent  |  |   |  |  |   |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>MARYLAND   |  | 10b. County<br>WICOMICO   |  | 10c. City, Town or Location<br>SALISBURY   |   |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br>208 TILHMAN DRIVE  |  |   |  | 10f. Zip Code<br>21804   |   | 10g. Citizen of What Country?<br>USA   |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4  |  |   |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>TENDEED CHICKENS  |   |  | 18b. Kind of Business/Industry<br>HATCHERY                       |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>ALVIN P. KELLER   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>ELSIE A. MARVEL   |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>ROBERT L. THORNTON (SON)   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2214 NORTHWOOD DRIVE, SALISBURY, MD 21804   |   |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>MCCOLLEYS CEMETERY  |  | Date<br>2-12   |   | 20c. Location - City or Town, State<br>GEORGETOWN, DE                                |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>George M. Shat</i>   |  |   |  | 22. Name and Address of Facility<br>SHORT FUNERAL SERVICES INC<br>PO BOX 233, MILTON, DE 19968   |   |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <i>Rheumatoid arthritis</i><br>Due to (or as a consequence of):<br>b. <i>Coronary vascular accident</i><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><i>yes</i><br><i>months</i> |  |   |  |  |   |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |   |  |  |  |  |
| State Registrar  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |  |   |  |  |  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |  |   |  |  |  |  |
| 29b. Signature and title of certifier<br><i>W. Robins</i>  |  |  |   |  | 29c. License number<br>D-29349   |   | 29d. Date signed (Month, Day, Year)<br><i>2/10/97</i>                                |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>WILLIAM ROBINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD. 21804   |  |  |   |  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 14 1997   |  |  |   |  | 32. Registrar's Signature<br><i>John A. Randall</i>  |   |  |  |  |  |

Baltimore, Maryland 21215-0020

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 06211

Reg. No.

|  |   |   |   |   |  |   |  |  |   |
|--|---|---|---|---|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MARY KAY Tyler</b>   |   |   |   | 2. Date of Death<br>Month <b>February</b> Day <b>13</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>0445</b>  |  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>   |   | 4c. County of Death<br><b>WICOMICO</b>   |  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-36-5863</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>JULY 5, 1940</b>   | 9. Birthplace (State or Foreign Country)<br><b>MD.</b>   |   |
|  | Usual Residence of Decedent   |   |   |   |  |   |  |  |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD.</b>  |   | 10b. County<br><b>WICOMICO</b>  |   | 10c. City, Town or Location<br><b>SALISBURY</b>  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
|  | 10e. Street and Number<br><b>121 CIVIC AVENUE</b>   |   |   |   | 10f. Zip Code<br><b>21804</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |
|  | 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>FOOD MANAGEMENT</b> |  |   | 16b. Kind of Business/Industry<br><b>RESTUARANT</b>  |  |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>EDWIN H. MORRIS</b>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MAUDE BRITTINGHAM</b>  |   |  |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>WAYNE TYLER- HUSBAND</b>   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>121 CIVIC AVENUE, SALISBURY, MD. 21804</b>   |   |  |  |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cramation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>PARSONS CEMETERY</b>   |   | Date<br><b>2/17/97</b>   | 20c. Location - City or Town, State<br><b>SALISBURY, MD.</b>  |  |  |   |
|  | 21. Signature of Funeral Service Licensee<br>   |   |   |   | 22. Name and Address of Facility<br><b>BOUNDS FUNERAL HOME, SALISBURY, MD. 21804</b>   |   |  |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. SMALL CELL CARCINOMA OF LUNGS</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Hepato renal failure</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |   |   |   |  |   |  |  | Approximate Interval Between Onset and Death<br><b>MONTHS</b> |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HEPATO RENAL FAILURE</b>   |   |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|  |   |   |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                   |  |  |   |
|  |   |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |
|  |   | 28d. Describe how injury occurred   |   |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>D36576</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/13/97</b>   |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>RONALD P. TRUITT 560 RIVERSIDE DR SALISBURY MD 21801</b>  |   |   |   |   |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 14 1997</b>  |   | 32. Registrar's Signature<br>  |   |   |  |   |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06212

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Wheaton

VAUGHN

Sr.

2. Date of Death

February 14 97

3. Time of Death

2:58P

4e. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

110-10-5906

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 8, 1912

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Greensboro

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

513 Bernard Ave.

10f. Zip Code

21639

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

18a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

florist/landscaper

18b. Kind of Business/Industry

retail

17. Father's Name (First, Middle, Last)

John Raymond Vaughn

18. Mother's Name (First, Middle, Maiden Surname)

Grace Marie Couture Vaughn

19a. Informant's Name/Relationship (Type, Print)

Lorlane M. Vaughn

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

513 Bernard Ave. Greensboro, Maryland 21639

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Greensboro Cemetery

Date

2/18

20c. Location - City or Town, State

Greensboro, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleegle-Helfenbein Funeral Home  
P.O. Box 160 Greensboro, Maryland 2163923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

a.

UROSEPSIS

Due to (or as a consequence of):

b.

PNEUMONIA

Due to (or as a consequence of):

c.

DEHYDRATION

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

2/12/97 days

2/11/97 days

2/11/97 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D35048

29d. Date signed (Month, Day, Year)

2/14/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eric F. Ciganek, M.D. 109 S. Commerce Street Centreville, MD 21617

31. Date filed (Month, Day, Year)

FEB 18 '97

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06213

|  |   |   |  |  |  |   |  |   |  |
|--|---|---|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>RICHARD M WAREHIME</b>   |   |  |  | 2. Date of Death<br>Month <b>2</b> Day <b>16</b> Year <b>97</b>  |   | 3. Time of Death<br><b>1238</b>  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Carroll County General Hospital</b>  |   |  |  | 4b. City, Town, or Location of Death<br><b>Westminster</b>   |   | 4c. County of Death<br><b>Carroll</b>  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-14-6550</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 28, 1922</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
|  | Usual Residence of Decedent   |   |  |  |  |   |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Carroll</b>  |  | 10c. City, Town or Location<br><b>New Windsor</b>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
|  | 10e. Street and Number<br><b>308 Maple Ave.</b>   |   |  |  | 10f. Zip Code<br><b>21776</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1943-46</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>1</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>district manager</b>                             |  | 16b. Kind of Business/Industry<br><b>automobile club</b>   |   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Russell Anana Warehime</b>  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Myers</b>   |   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary E. Warehime/ wife</b>   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>308 Maple Ave. New Windsor, MD 21776</b>   |   |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Pleasant Valley Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>2/19/97 Pleasant Valley, MD</b>  |   |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Catherine O. Hartzler</b>   |   |  |  | 22. Name and Address of Facility<br><b>Hartzler Funeral Home<br/>New Windsor, MD</b>   |   |  |   |  |
|  | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Approximate Interval Between Onset and Death<br><b>a. Metastatic liver disease. 1 month</b><br><b>b. Adenocarcinoma of colon. 6 mo</b><br><b>c.</b><br><b>d.</b>   |   |  |  |  |   |  |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>23b. Did tobacco use contribute to the cause of death?</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown<br><b>24a. Was an autopsy performed?</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>24b. Were autopsy findings available prior to completion of cause of death?</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                           |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><b>Chitrachedu Naganna</b>   |  | 29c. License number<br><b>D18 800</b>            |  | 29d. Date signed (Month, Day, Year)<br><b>2/16/97</b>                                       |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Chitrachedu Naganna 700A Poole Rd. Westminster, MD 21157</b>  |   |   |  |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 18 1997</b>  |   | 32. Registrar's Signature<br><b>John Davidson Russell</b>   |  |  |  |   |  |   |  |





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06214

|  |   |  |   |   |  |
|--|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Patricia Ann WATSON</b>  |  | 2. Date of Death<br>Month <b>Feb.</b> Day <b>17</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>9:00 P.M.</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Washington County Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>   |   | 4c. County of Death<br><b>Washington</b>   |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-42-2850</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>52</b> Yrs.  | If Under 1 Year<br>Months Days                              | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>June 10 1944</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |  | 10c. City, Town or Location   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 10a. State<br><b>W. Va.</b>   | 10b. County<br><b>Berkeley</b>   | <b>Falling Waters</b>   |   |  |
|  | 10e. Street and Number<br><b>P.O. Box 222 Evergreen Circle</b>  |  | 10f. Zip Code<br><b>25419</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0-12</b> College (1-4 or 5+) <b>0</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Anaylist</b>  |   | 16b. Kind of Business/Industry<br><b>Merchant Services</b>   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Paul E. Palladino, Sr.</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Frances L. LaPole</b>   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Michael R. Watson</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 222 Falling Waters, W. Va. 25419</b>   |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rose Hill Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>2/20/97 Hagerstown, Maryland</b>   |
|  | 21. Signature of Funeral Service Licensee<br><i>Scott Minnich</i>   |  | 22. Name and Address of Facility<br><b>Minnich Funeral Home<br/>415 E. Wilson Blvd. Hagerstown, Maryland</b>  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |   |  |
| Physician<br>/Medical<br>Examiner  | Immediate Cause (Final disease or condition resulting in death)   |  | a. <b>lung Cancer</b>   |   | Approximate Interval Between Onset and Death<br><b>8 months</b>  |
|  | Due to (or as a consequence of):  |  | b.  |   |  |
|  | Due to (or as a consequence of):  |  | c.  |   |  |
|  | Due to (or as a consequence of):  |  | d.  |   |  |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |
|  | 23c. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |   |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |
|  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |   |  |
| 29b. Signature and title of certifier<br><i>Hind Hamdan, MD</i>  |   | 29c. License number<br><b>D46473</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>Feb. 18, 1997</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Hind Hamdan, MD 363 S. Cleveland Ave.; Hagerstown, MD 21740</b>   |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 20 1997</b>  |   | 32. Registrar's Signature<br><i>John Anderson-Randall</i>                    |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



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State of Maryland / Department of Health and Mental Hygiene

97 06215

## Certificate of Death

Reg. No.

|   |   |  |  |  |   |  |   |  |
|---|---|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CHARLES EDWARD WOLPERT</b>   |  |  | 2. Date of Death<br>Month <b>February</b> Day <b>13</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>3:25 AM</b>   |   |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>VA Maryland Health Care System</b>   |  |  | 4b. City, Town, or Location of Death<br><b>Perry Point</b>   |   | 4c. County of Death<br><b>Cecil</b>  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>155-10-1571</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>94</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 23, 1902</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Cecil</b>   |  | 10c. City, Town or Location<br><b>Perryville</b>  |  |
| To Be Completed by Funeral Director   | 10e. Street and Number<br><b>1836 Perryville Road</b>   |  | 10f. Zip Code<br><b>21903</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1942-45</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) Three Years</b>   |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Maintenance</b>                                   |  | 16b. Kind of Business/Industry<br><b>Craft Haven Marine Perryville, Maryland</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Charles A. Wolpert</b>  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Flora Paffe</b>  |   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>James Dooling (Nephew)</b>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16 Cedar Street, Pocomoke City, Maryland 21851</b> |   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Immaculate Conception Cemetery</b>  |  | Date<br><b>2/15/97</b>  |  | 20c. Location - City or Town, State<br><b>Elkton, Maryland</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Thomas M. Patterson Sr.</b>   |  |  | 22. Name and Address of Facility<br><b>Lee A. Patterson &amp; Son Funeral Home Perryville, Maryland 21903-0188</b>                                     |   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
|   | e. <b>Sepsis</b><br>Due to (or as a consequence of):<br>b. <b>Pneumonia</b><br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____   |  |  |  |   |  |   | 2 days<br>2 days   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia</b>   |  |  |  |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |   |  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
|   |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28d. Describe how injury occurred  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |  |   |  |   |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>   |   |  | 29c. License number<br><b>D20215</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>February 13, 1997</b>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>KARMACHANDRA S. NAIR, M.D., VA Maryland Health Care System, Perry Point, MD 21902</b>  |   |  |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 14 1997</b>   |   | 32. Registrar's Signature<br><b>[Signature]</b>  |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



97 06216

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MILDRED G. WARD</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 14, 1997</b>  |  | 3. TIME OF DEATH<br><b>8:45 A. M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-34-3793</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Oct. 8, 1917</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Home- 2816 Byrdtown Road</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Crisfield, MD</b>   |  | 9c. COUNTY OF DEATH<br><b>Somerset</b>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Somerset</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Crisfield</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>2816 Byrdtown Road</b>  |  |  |  | 10f. ZIP CODE<br><b>21817</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Grade 6</b> College (1-4 or 5+) <b>— — —</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Seamstress</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Clothing</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Oscar Lawson</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Nora B. Sterling</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>William Zach Ward (Son)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2816 Byrdtown Road - Crisfield, MD 21817</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Asbury Cemetery</b>  |  | DATE<br><b>2/17/97</b>  |  | 20c. LOCATION — City or Town, State<br><b>Crisfield, MD</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert H. Bradshaw, Jr.</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Bradshaw &amp; Sons Funeral Home<br/>306 W. Main St. - Crisfield, MD 21817</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARCINOMA Ovary</b>   |  |  |  |   |  |   |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |   |  |
| b. <b>metastasis to peritoneum</b>   |  |  |  |   |  |   |  |
| c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>   |  |  |  |   |  |   |  |
| d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Other (Specify)   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>M. D. Barhan</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>12764</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/17/97</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Madhav D. Barhan, M.D. - 4384 Crisfield Highway - Crisfield, MD 21817</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 19 1997</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



97 06217

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Thomas P. Walsh</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 15, 1997</b>  |  | 3. TIME OF DEATH<br><b>2325 P M.</b>                                    |  |
| 4. SOCIAL SECURITY NUMBER<br><b>222-32-1158</b>   |  | 5. SEX<br><b>1 M 2 F</b>   |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 27, 1912</b>            |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>   |  |  |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br><b>Elkton</b>  |  | 9b. COUNTY OF DEATH<br><b>Cecil</b>                                     |  |
| 9c. FACILITY NAME (If not institution, give street and number)<br><b>Laurelwood Center</b>  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Cecil</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Childs</b>  |  | 10d. INSIDE CITY LIMITS?<br><b>1 YES 2 NO</b>                           |  |
| 10e. STREET AND NUMBER<br><b>1120 Blue Ball Road</b>  |  |  |  | 10f. ZIP CODE<br><b>21916</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                   |  |
| 11. MARITAL STATUS<br><b>1 X Never Married 2 Married 3 Widowed 4 Divorced</b>   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b><br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 NO</b> Specify:     |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Roman Catholic Priest</b>           |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Education</b>  |  |   |  |
| 16. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>College (1-4 or 5+)</b>   |  |  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Thomas Walsh</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary McCabe</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Rev. Francis Hanlon, O.S.F.S.</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 1452, Wilmington, Delaware 19806</b> |  |   |  |
| 20a. METHOD OF DISPOSITION<br><b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 8 Other (Specify)</b>   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Oblate Community Cemetery 2/21/97 Childs, Maryland</b>         |  | 20c. LOCATION — City or Town, State   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James S. Hicks</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hicks Home for Funerals, P.A.<br/>103 W. Stockton St., Elkton, Maryland 21921</b>                          |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |  |  |   |  |   |  |
| a. <b>CORONARY ARTERY DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| b. <b>ARTERIOSCLEROSIS, GENERALIZED</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| c. <b>ATHEROSCLEROSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| d. <b>CANCER OF PROSTATE GLAND</b>  |  |  |  |   |  |   |  |
| 24. SEQUENTIALLY LIST CONDITIONS, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 NO</b>   |  |  |  |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 NO</b>  |  |  |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH <b>YES X NO UNCERTAIN</b>  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 NO</b>   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 8 Other (Specify)</b> |  |   |  |   |  |
| 27. MANNER OF DEATH<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 8 Could not be determined</b>   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>                               |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
|   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Julius D. Nijel</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D 07863</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/17/97</b>                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Kolando Najera MD 118 NORTH STREET ELKTON MARYLAND 21921</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 18 1997</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06218

## Certificate of Death

Reg. No.

|  |   |  |   |   |   |  |   |   |   |
|--|---|--|---|---|---|--|---|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>GEORGE MELVIN WILKINSON   |  |   |   | 2. Date of Death<br>Month Day Year<br>FEB. 14 1997  |  | 3. Time of Death<br>6:15 A.M.   |   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br>105 KENDALL STREET  |  |   |   | 4b. City, Town, or Location of Death<br>SALISBURY   |  | 4c. County of Death<br>WICOMICO   |   |   |
| Funeral<br>Director  | 5. Social Security Number<br>215-20-1822  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>68 Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>JUNE 17 1928  |   | 9. Birthplace (State or Foreign Country)<br>MD. |   |
|  | Usual Residence of Decedent   |  |   |   |   |  |   |   |   |
| To Be Completed by Funeral Director  | 10a. State<br>MD.   | 10b. County<br>WICOMICO  | 10c. City, Town or Location<br>SALISBURY  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |   |   |
|  | 10e. Street and Number<br>105 KENDALL STREET  |  |   | 10f. Zip Code<br>21804  |   | 10g. Citizen of What Country?<br>U.S.A.  |   |   |   |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: WWII KOREA MARINE |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE  |   |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>12  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>DEPUTY SHERIFF   |   |   | 16b. Kind of Business/Industry<br>COUNTY GOVERNMENT  |   |   |   |
|  | 17. Father's Name (First, Middle, Last)<br>ALBERT K. WILKINSON  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>FRANCES DONOWAY  |  |   |   |   |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>PHYLLIS WILKINSON-WIFE  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>105 KENDALL STREET, SALISBURY, MARYLAND 21804  |   |  |   |   |   |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>SPRINGHILL MEMORY GDNS.   |   | Date<br>2/18/97   |  | 20c. Location - City or Town, State<br>HEBRON, MARYLAND   |   |   |
|  | 21. Signature of Funeral Service Licensee<br>Gerald C. Bounds   |  |   | 22. Name and Address of Facility<br>BOUNDS FUNERAL HOME, SALISBURY, MD. 21804   |   |  |   |   |   |
|  | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. CARCINOMA LIVER WITH METASTASIS<br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |   |  |   |   |   |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>CHRONIC OBSTRUCTIVE PULMONARY DISEASE  |   |  |   |   |   |  |   |   |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |   |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of injury (Month, Day Year)                                      |   | 28b. Time of injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No           |   | 28d. Describe how injury occurred               |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |   |   |  |   |   |   |
| 29b. Signature and title of certifier<br>A. Pol...   |   |  |   | 29c. License number<br>D42522   |   | 29d. Date signed (Month, Day, Year)<br>2/14/97   |   |   |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>PRAKASH DALAL, MD 614 Eastern Shore Drive, Salisbury, MD 21801   |   |  |   |   |   |  |   |   |   |
| 31. Date filed (Month, Day, Year)<br>FEB 14 1997   |   |  |   | 32. Registrar's Signature<br>John Davidson-Hardall  |   |  |   |   |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06219

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Elizabeth Webb YORK

2. Date of Death

February 14 1997

3. Time of Death

1310

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

216-38-0147

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

May 13, 1939

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11213 Piper Lane

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Sarah D. Webb

19a. Informant's Name/Relationship (Type, Print)

Charles William York, Sr. Husband 11213 Piper Lane Hagerstown, MD 21740

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Lawn Memorial Park 2-18-97

Date

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Osborne Funeral Home 425 S. Conococheague St.  
Williamsport, MD 21795

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Renal Failure  
Due to (or as a consequence of):

Approximate interval Between Onset and Death

3 days

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Sepsis Pneumonia  
Due to (or as a consequence of):

3 days

c. Multiple myeloma  
Due to (or as a consequence of):

13 months

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

A73623

29d. Date signed (Month, Day, Year)

2/14/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fif. Kass III MD 1110 Medical Campus Dr Hagerstown Md

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Julia Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06220

## Certificate of Death

Reg. No.

|  |  |  |   |                                |  |
|--|--|--|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>CHARLOTTE MILENNA YOUNG</b>   |  | 2. Date of Death<br>Month Day Year<br><b>Feb. 15, 1997</b>  |                                | 3. Time of Death<br><b>1:45 AM</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Salisbury Center; Genesis ElderCare</b>   |  | 4b. City, Town, or Location of Death<br><b>Salisbury, Md.</b>   |                                | 4c. County of Death<br><b>Wicomico</b>   |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-34-9096</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>94</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>July 31, 1902</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |                                |  |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Wicomico</b>  |                                | 10c. City, Town or Location<br><b>Salisbury</b>  |
|  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                |  |
|  | 10e. Street and Number<br><b>1514 Riverside Dr., Apt. 215A</b>   |  | 10f. Zip Code<br><b>21801</b>   |                                | 10g. Citizen of What Country?<br><b>USA</b>  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |                                |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>7</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Nurse</b>                         |                                | 16b. Kind of Business/Industry<br><b>Medicine</b>  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Caleb C. Cooper</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Fooks</b>  |                                |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Michael Warfel/executor</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2201 Aspen Way, Harrisburg, PA</b>            |                                |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Wicomico Memorial Park</b>   |                                | 20c. Location - City or Town, State<br><b>2/18/97 Salisbury, Maryland</b>  |
|  | 21. Signature of Funeral Service Licensee<br><b>David H. Thompson</b> MO1051   |  | 22. Name and Address of Facility<br><b>Holloway Funeral Home<br/>501 Snow Hill Rd., Salisbury, MD 21804</b>                                       |                                |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. PNEUMONIA</b><br>Due to (or as a consequence of):<br><b>b. Pneumonia</b><br>Due to (or as a consequence of):<br><b>c. Advanced Age + Debilitated</b><br>Due to (or as a consequence of):<br><b>CONDITION</b><br>d. |  |   |                                | Approximate Interval Between Onset and Death<br><b>5 Days</b>  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |                                |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |                                |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |                                | 28b. Time of Injury<br><b>M</b>  |
|  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how Injury occurred   |                                |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |
| State Registrar  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |                                |  |
|  | 29b. Signature and title of certifier<br><b>Dr. AT MD</b>  |  | 29c. License number<br><b>D39813</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>2/17/97</b>  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dr. ARTHUR MD 1104 HEALTHWAY DR., SALISBURY, MD. 21804</b>  |  |   |                                |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 18 1997</b>              |  |  |   |                                | 32. Registrar's Signature<br><b>John Davidson-Randall</b>  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06221

## Certificate of Death

Reg. No.

|   |   |  |   |   |  |  |   |  |  |   |  |
|---|---|--|---|---|--|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Erna Emile Zeeb   |  |   |   | 2. Date of Death<br>Month Day Year<br>Feb. 17 1997   |  |   |  | 3. Time of Death<br>10:55 AM   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Waldorf Healthcare Center   |  |   |   | 4b. City, Town, or Location of Death<br>Waldorf  |  |   |  | 4c. County of Death<br>Charles   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br>577-54-5750  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>77 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Oct. 17 1919   |  | 9. Birthplace (State or Foreign Country)<br>Germany  |   |  |
|   | Usual Residence of Decedent   |  |   |   |  |  |   |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br>MD  |  | 10b. County<br>Charles  |   | 10c. City, Town or Location<br>LaPlata   |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br>7420 St. Mary's Ave.  |  |   |   | 10f. Zip Code<br>20646   |  | 10g. Citizen of What Country?<br>U.S.A.               |  |  |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 Collage (1-4or 5+)  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Motel Owner   |  |   | 16b. Kind of Business/Industry<br>Lodging                        |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Robert Hedwig  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Emma Kohler Hedwig  |  |   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Arlene V. Jenkins   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>16001 Crain Hwy. Brandywine, MD 20613   |  |   |  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>MD Vet. Cemetery  |   | Date<br>2/20/97  |  | 20c. Location - City or Town, State<br>Cheltenham, MD |  |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>David C. Echols</i> MO0945  |  |   |   | 22. Name and Address of Facility<br>AREHART-ECHOLS FUNERAL HOME, INC.<br>P.O. Box 567 LaPlata, MD 20646  |  |   |  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <i>Chronic obstructive pulmonary disease</i><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |   |  |  |   |  |  |   | Approximate Interval Between Onset and Death   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |   |  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)                     |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred                                |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |   |  |  |   |  |  |   |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |   |  |   | 29c. License number<br>D22574   |  |  |   | 29d. Date signed (Month, Day, Year)<br>2-18-97                   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>P.O. Box 249 - Waldorf F. Md. 20604   |   |  |   |   |  |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>FEB 19 1997  |   | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i> |   |   |  |  |   |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06222

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Constance Williams Abercrombie

2. Date of Death

FEB 27

Day Year

1997

3. Time of Death

9:10 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

2625 Laurel Brook Road

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

5. Social Security Number

075-10-2000

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

OCT 30, 1915

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Fallston

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

2625 Laurel Brook Road

10f. Zip Code

21047

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George Fitzgerald Williams

18. Mother's Name (First, Middle, Maiden Summa)

Lillian Mae Burgess

19a. Informant's Name/Relationship (Type, Print)

Enid A. Allen/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2105 Thomas Run Rd. Bel Air, MD 21015

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 2/28/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

George E. MacNabb

22. Name and Address of Facility

Cremation Society of Maryland, Inc.

299 Frederick Rd. Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ADENOCARCINOMA of UNKNOWN PRIMARY 1 YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

231775

29d. Date signed (Month, Day, Year)

FEBRUARY 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDWARD P. EDWARDS, MD

2112 BEL AIR RD

FALLSTON, MD

21047

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: This requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit.



Handwritten text at the bottom center, possibly a signature or date.

Handwritten text at the bottom right, possibly a date or initials.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06223

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CARL ATKINS

2. Date of Death

Month

Day

Year

FEBRUARY 17

1997

9:20 P.M.

3. Time of Death

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

224-12-5835

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

JULY 8, 1907

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

VA

10b. County

Roanoke

10c. City, Town or Location

Roanoke

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1501 9th St., S.E.

10f. Zip Code

24013

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Barber

16b. Kind of Business/Industry

Self-employed

17. Father's Name (First, Middle, Last)

William J. Atkins

18. Mother's Name (First, Middle, Maiden Surname)

Josephine King

19a. Informant's Name/Relationship (Type, Print)

Dennis Atkins - nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 Ridge Road, Catonsville, Md. 21228

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory, Inc.

Date

2/19/97

20c. Location - City or Town, State

Beltsville, Md.

21. Signature of Funeral Service Licensee

Steven Hullman

22. Name and Address of Facility

Gary L. Kaufman Funeral Home at Meadowridge

7250 Washington Blvd., ElkrIDGE, MD

21227

23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

7 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

20 YEARS

c. CHRONIC HEART FAILURE

Due to (or as a consequence of):

20 YEARS

d. ATHEROSCLEROTIC HEART DISEASE

20 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HIP FRACTURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☒ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

2/7/97

28b. Time of Injury

P M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

FELL

28e. Place of Injury (At home, farm, street, factory, office building, etc. (Specify))

Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Baltimore, Md. 2 Rd 94 Rd 21136

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. Akbarov

29c. License number

P09152

29d. Date signed (Month, Day, Year)

2/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. Akbarov, MD

900 Caton Ave., Baltimore, Md.

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Coroner: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: This certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 17, 19a Per FH Film G745 3-4-97 rja

## Certificate of Death

Reg. No.

97 06224

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles W. Andersen

2. Date of Death

Month  
MARCHDay  
01Year  
97

3. Time of Death

02:00 AM

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical System

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral  
Director

5. Social Security Number

068-34-8886

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)  
Oct. 11, 1942

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10e. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

8240 Fairwood Drive

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No 1964  
If Yes, Give Year or Dates: 1984

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
+ 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Investigator

16b. Kind of Business/Industry

U.S. Army

17. Father's Name (First, Middle, Last)

Andersen  
Charles W. Andersen

18. Mother's Name (First, Middle, Maiden Surname)

Catherine A. York

19a. Informant's Name/Relationship (Type, Print)

Andersen  
Annie M. Andersen Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8240 Fairwood Drive Pasadena, Maryland 21122

20e. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cem. 3-5-1997

Date

20c. Location - City or Town, State

Arlington, Va.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully Funeral Home  
3204 Mountain Road Pasadena, Maryland 21122

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multi-system organ failure  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Pneumonia  
Due to (or as a consequence of):

7 days

c. Immune suppression  
Due to (or as a consequence of):

2 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accidental ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Surgical Resident MD

29c. License number

P04777

29d. Date signed (Month, Day, Year)

03/01/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jason Sperling, MD Dept of Surgery 22 S. Greene St Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The attending physician has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The attending physician has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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1. 19

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2. 20

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(A)

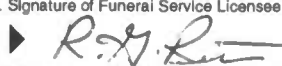
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06225

## Certificate of Death

Reg. No.

|  |  |                                 |   |  |  |   |  |  |
|--|--|---------------------------------|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>LOUISE SUDBURY ANDREWS</b>  |                                 |   |  | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 28, 1997</b>   |   | 3. Time of Death<br><b>11:15 P.</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>BROADMEAD RETIREMENT COMMUNITY</b>  |                                 |   |  | 4b. City, Town, or Location of Death<br><b>COCKEYSVILLE</b>  |   | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-46-2703</b>  |                                 | 6. Sex<br>1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>101</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                    | 8. Date of Birth (Month, Day, Year)<br><b>10-01-1895</b>   | 9. Birthplace (State or Foreign Country)<br><b>INDIANA</b> |
|  | Usual Residence of Decedent  |                                 |   |  |  |   |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>MD.</b>   | 10b. County<br><b>BALTIMORE</b> |   | 10c. City, Town or Location<br><b>COCKEYSVILLE</b>   |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>13801 YORK ROAD</b>   |                                 |   | 10f. Zip Code<br><b>21030</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>    |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br><b>XX</b> <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                          |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8 YEARS</b> College (1-4or 5+)   |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEWIFE</b>                       |  |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b> |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>BEDFORD SUDBURY</b>  |                                 |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>NELLY HOUGH</b>  |   |  |  |
| Physician<br>/Medical<br>Examiner                                    | 19a. Informant's Name/Relationship (Type, Print)<br><b>CAROL ANN WILDESEN (ATTO.)</b>  |                                 |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>329B 22 W. PADONIA RD., TIMONIUM, MD., 21093</b>   |   |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GREEN MOUNT CREMATORY</b>  |  | Date<br><b>3-3-97</b>  |   | 20c. Location - City or Town, State<br><b>BALTO., MD. 21202</b>                                  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |                                 |   |  | 22. Name and Address of Facility<br><b>HENRY W. JENKINS AND SONS COMPANY<br/>4905 YORK ROAD, BALTIMORE, MARYLAND, 21212</b>  |   |  |  |
|  | 23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>PNEUMONIA</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Approximate interval Between Onset and Death<br><b>2wk</b> |                                 |   |  |  |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEMENTIA</b>  |                                 |   |  |  |   |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                 |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |                                 | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No             |  |
|  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |                                 |   |  | 28d. Describe how injury occurred  |   |  |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                 |   |  |  |   |  |  |
|  | 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |                                 |   |  |  |   |  |  |
| State<br>Registrar   | 29b. Signature and title of certifier<br>   |                                 |   |  | 29c. License number<br><b>D38392</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>MARCH 1, 1997</b>                                      |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BARBARA CARROLL, M.D., 13801 YORK ROAD, COCKEYSVILLE, MARYLAND, 21030</b>   |                                 |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>              |  |                                 |   | 32. Registrar's Signature<br> |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

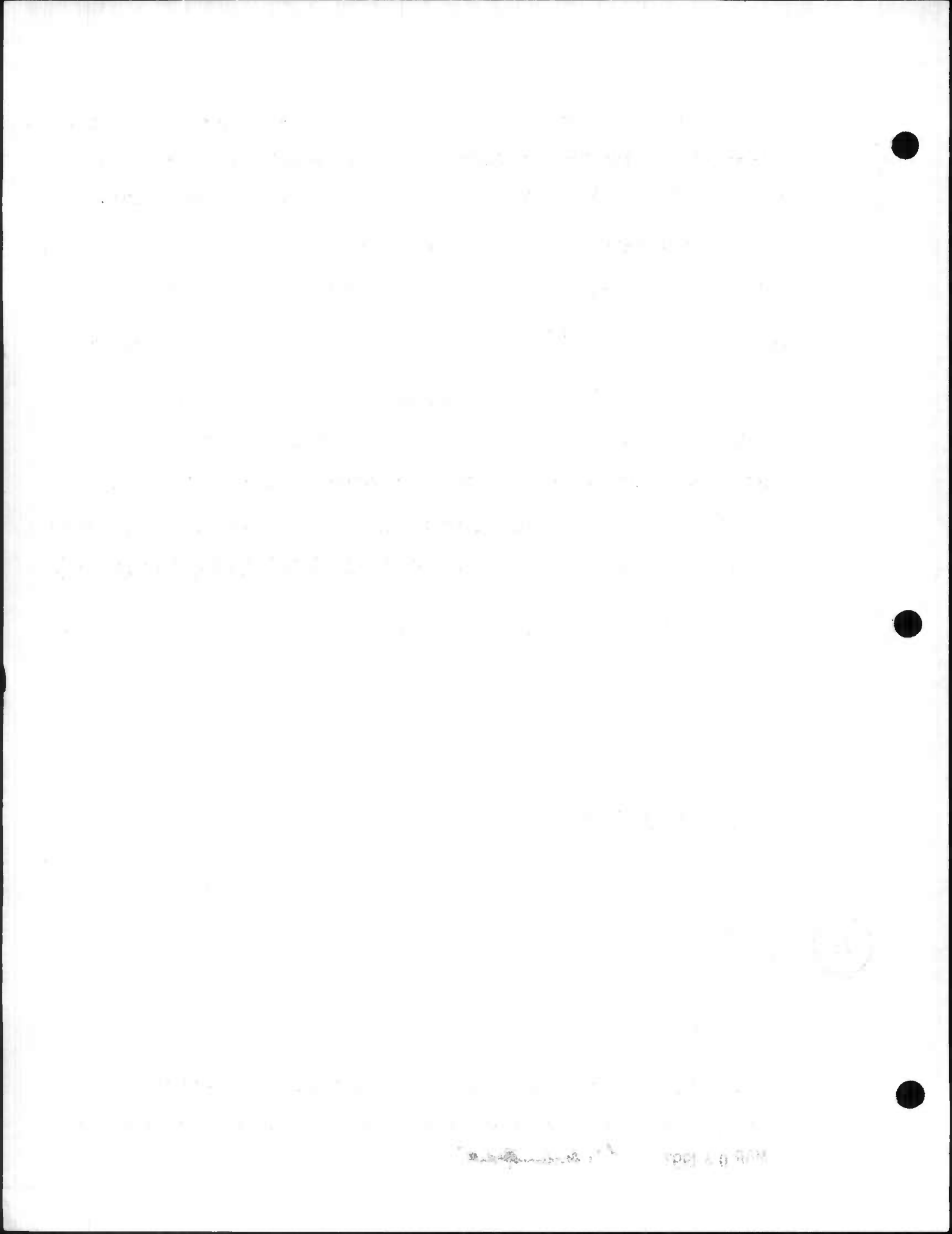
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director.

Medical Certification: To Be Completed by Physician/Medical Examiner





97 06226

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |  |   |   |
|---|--|--|---|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>EDWARD D. ALEXANDER   |  |  |   | 2. DATE OF DEATH<br>MONTH FEBRUARY DAY 25, 97 YEAR  |  | 3. TIME OF DEATH<br>0:253 A.M.  |   |
| 4. SOCIAL SECURITY NUMBER<br>213 36 3186  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>55 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>7/1/41  |  | 8. BIRTHPLACE (State or Foreign Country)<br>MD.   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>UNION MEMORIAL HOSPITAL   |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  | 9c. COUNTY OF DEATH<br>BALTO. CITY  |   |
| RESIDENCE OF DECEDENT   |  |  |   |   |  |   |   |
| 10a. STATE<br>MD.   |  | 10b. COUNTY<br>BALTO. CITY   |   | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>1806 W. NORTH AVE.  |  |  |   | 10f. ZIP CODE<br>21217  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: AFRO AMER.                               |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Laborer   |   | 16b. KIND OF BUSINESS/INDUSTRY<br>ACCO. COMPANY   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>NATHANIEL ALEXANDER  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>DOROTHY ALEXANDER  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>CYNTHIA ALEXANDER SISTER  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3010 BRIGHTON ST. BALTO. MD. 21216   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place)<br>MT. ZION CEM. 2/28/97   |   | DATE  |  | 20c. LOCATION — City or Town, State<br>Lansdowne, MD.   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Cecil A. Estep</i>  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>ESTEP BROTHERS FUNERAL HOME P.A.<br>1300 EUTAW PLACE BALTO. MD. 21217   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Aortic valve endocarditis & vegetations<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. Intravenous drug abuse<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |   |   |  |   | Approximate Interval Between Onset and Death<br>1 day<br>1 month<br>> 10 yrs  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>History of Recent Endocarditis (Jan, 97)<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |  |   |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |   | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |   | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |   |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Regina, M.D.</i>  |  |  |   | 29c. LICENSE NUMBER<br>AT 2438946   |  | 29d. DATE SIGNED (Month, Day, Year)<br>Feb, 27, 1997  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>SURAIYA BELOUM, MD. UNION MEMORIAL HOSPITAL<br>201 E. UNIVERSITY PKWY, BALTIMORE, MD - 21218   |  |  |   |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>MAR 04 1997  |  |  |   | 32. REGISTRAR'S SIGNATURE<br><i>Widom-Ronde</i>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The death certificate is to be completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

22



97 06227

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>DOROTHY D. ALPERSTEIN</u>   |  |  |  | 2. DATE OF DEATH<br>MONTH <u>February</u> DAY <u>25</u> YEAR <u>1997</u>  |  | 3. TIME OF DEATH<br><u>6:20 A M</u>   |  |
| 4. SOCIAL SECURITY NUMBER<br><u>215-05-0846</u>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><u>84</u> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><u>JULY 24, 1912</u>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><u>RUSSIA</u>  |  | 9a. FACILITY NAME (If not Institution, give street and number)<br><u>PIKESVILLE NURSING HOME</u>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>PIKESVILLE</u>  |  | 9c. COUNTY OF DEATH<br><u>BALTIMORE</u>   |  |
| 10a. STATE<br><u>MD</u>  |  | 10b. COUNTY<br><u>BALTIMORE</u>  |  | 10c. CITY, TOWN OR LOCATION<br><u>BALTIMORE</u>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><u>7204 VALLEY COUNTRY CT.</u>   |  |  |  | 10f. ZIP CODE<br><u>21208</u>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>WHITE</u>                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (14 or 5+) <u>12</u>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><u>HOMEMAKER</u>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>OWN HOME</u>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>EMANUEL DAHNE</u>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>ROSE KATZ</u>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>ALLAN ALPERSTEIN (SON)</u>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>7 STIRRUP CT. BALTIMORE, MD 21208</u>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>BETH JACOB</u>   |  | DATE<br><u>2/27/1997</u>  |  | 20c. LOCATION — City or Town, State<br><u>FINKSBURG, MD</u>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>William Levinson</u>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>SOL LEVINSON &amp; BROS., INC.</u><br><u>8900 REISTERSTOWN RD., PIKESVILLE, MD 21208</u>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>ATHEROSCLEROTIC CARDIOVASCULAR Disease</u>  |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  |  |  |   |  |   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Diabetes Mellitus</u>   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><u>N/A</u>   |  | 28b. TIME OF INJURY<br><u>M</u>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE NOW INJURY OCCURRED  |  |  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Harold B. Bous MD</u>  |  |  |  | 29c. LICENSE NUMBER<br><u>D15872</u>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>February 25, 1997</u>                                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>Harold B. Bous MD 7220 Park Heights BALTIMORE 21208</u>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><u>MAR 04 1997</u>  |  | 32. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Rendell</u>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06228

## Certificate of Death

Reg. No.

|   |   |   |  |  |   |  |  |  |
|---|---|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Inza Margaret Braxton</b>  |   |  |  | 2. Date of Death<br>Month <b>FEB</b> Day <b>26</b> Year <b>1997</b> |  | 3. Time of Death<br><b>11:45 AM</b>                        |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Lorien Nursing and Rehabilitation Center</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Columbia</b>             |  | 4c. County of Death<br><b>Howard</b>                       |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>199-07-6836</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.                    |  | 8. Date of Birth (Month, Day, Year)<br><b>AUG 22, 1920</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>   |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>            |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 10e. Street and Number<br><b>4815 Lindsay Road Apt. 2C</b>  |  | 10f. Zip Code<br><b>21229</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                                      |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>          |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Clerical</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Accounting</b>                    |  | 16b. Kind of Business/Industry<br><b>Accounting</b>  |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Charles Henry Taylor</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Charlotte Louise Barraud</b>   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joyce Eileen Coley/daughter</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4815 Lindsay Rd. Apt 1A, Baltimore, MD 21228</b>   |   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>  |  | Date<br><b>2/27/97</b>   |   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>                      |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Shaun McDonald</i>  |   |   |  | 22. Name and Address of Facility<br><b>Cremation Society of Maryland, Inc.<br/>299 Frederick Road Baltimore, MD 21228</b>  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Advanced metastatic right breast Carcinoma</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |   |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |   |   |  | 29c. License number<br><b>D31927</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>2-27-97</b>                            |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>HO-LAI FENG, MD, Two Knoll North Dr. Columbia, MD 21045</b>  |   |   |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>   |   |   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



*[Faint, illegible handwritten text]*

Items: 23a part II, 27, 28a-f per MD G-749 7/29/97 dh  
 Item 1 Per PHY Film G745 3-4-97 rja

## Certificate of Death

Reg. No.

97 06229

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert

A.

Barlow

2. Date of Death

February 13, 1997

3. Time of Death

12:30PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Physicians Memorial Hospital

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

5. Social Security Number

489-24-2776

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

OCT. 19, 1922

9. Birthplace (State or Foreign Country)

MO. LOCKSPRING

Usual Residence of Decedent

10a. State

MO.

10b. County

CARROLL

10c. City, Town or Location

HALE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

R.R. #2 BOX 122

10f. Zip Code

64643

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

FARMER

16b. Kind of Business/Industry

AGRICULTURE

17. Father's Name (First, Middle, Last)

GUY EARL BARLOW

18. Mother's Name (First, Middle, Maiden Surname)

CLARA COBERLEY

19a. Informant's Name/Relationship (Type, Print)

ANNA MAY BARLOW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

R.R. #2 BOX 122 HALE MO. 64643

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HURRICANE CEM.

Date

20c. Location - City or Town, State

HALE MO.

21. Signature of Funeral Service Licensee

Thomas J. Skarda Jr.

22. Name and Address of Facility

SKARDA FH. 2829 HUDSON ST. BALTIMORE, MD. 21224

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Sepsis  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Urinary tract infection  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

BROKEN HIP

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Pending investigation 3 ☐ Accident 4 ☐ Suicide 5 ☐ Could not be determined 6 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

Jan 31, 1997

28b. Time of Injury

8:00

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

fall from bed

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

11218 Carroll Dr.

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert Pace

29c. License number

D-22574

29d. Date signed (Month, Day, Year)

2/13/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Pace, MD., 700 Old Line Center, Suite 202, Waldorf, Maryland 20601

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

Davidson

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Handwritten signature or scribble

NOV 10 1964



## Certificate of Death

Reg. No.

|   |   |  |  |  |  |  |   |  |
|---|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>QUINTIN SILVESTER BROWN</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 28, 1997</b>   |  | 3. Time of Death<br><b>9:30AM</b>                                       |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>2418 EAST LAFAYETTE STREET</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>214-88-3602</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>33</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>JUL 22, 1963</b>              |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>                         |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>2418 Lafayette Avenue</b>   |  | 10f. Zip Code<br><b>21213</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>  |  | 16b. Kind of Business/Industry<br><b>Construction</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Roy Prentice Brown</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edna Virginia Johnson</b>  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Edna V. Brown / Mother</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2418 Lafayette Avenue Baltimore, MD 21213</b>  |  |  |  |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc. 03/04/97</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |  | 21. Signature of Funeral Service Licensee<br><b>George E. MacNabb</b>   |  |
| To Be Completed by Physician/Medical Examiner | 22. Name and Address of Facility<br><b>Cremation Society of Md., Inc.<br/>299 Frederick Road Baltimore, MD 21228</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Asphyxia</b><br><b>Strangulation</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |
|   | 23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |   |  |
|   | 28a. Date of Injury (Month, Day, Year)<br><b>2/28/97</b>  |  | 28b. Time of Injury<br><b>9:20 AM</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><b>subject strangled</b>           |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Home</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Baltimore, Md</b>   |  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
|   | 29b. Signature and title of certifier<br><b>Dennis J. Chute</b>   |  | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 1, 1997</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201</b>   |  | 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>  |  |  |  |   |  |
|   | 32. Registrar's Signature<br><b>[Signature]</b>   |  | 33. Registrar's Title<br><b>[Signature]</b>  |  |  |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06231

Item 8 Per FH Film G745 3-4-97 rja

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LA Rue Simmons Braun

2. Date of Death

MAR 3 1997

Day Year

3. Time of Death

0950

4a. Facility Name (If not institution, give street and number)

1212 Juneway Rd.

4b. City, Town, or Location of Death

Pasadena

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

194-20-3458

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

March 3, 1997

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1212 Juneway Road

10f. Zip Code

21122

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Theodore

Evans

18. Mother's Name (First, Middle, Maiden Surname)

Irene

Simmons

19a. Informant's Name/Relationship (Type, Print)

Mr. Ferdinand C. Braun (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1212 Juneway Road Pasadena, Maryland 21122

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Cemetery

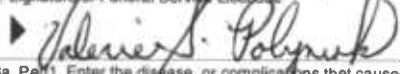
Date

3/4/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Mc Cully Funeral Home of Pasadena  
3204 Mountain Road Pasadena, Maryland 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Acute Cardiac Insufficiency UNK

Due to (or as a consequence of):

b. Arteriosclerotic Heart Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Alcohol Use

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

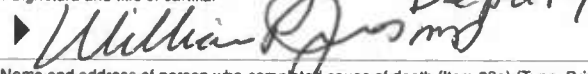
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D 06054

29d. Date signed (Month, Day, Year)

3/3/97

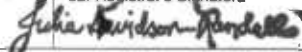
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

William P. Jones, MD 695 America 21035

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature


State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Handwritten text at the top of the page, mostly illegible due to fading.

9

Handwritten text at the bottom of the page, including a date stamp that reads "JAN 10 1931".

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06232

Reg. No.

|  |  |  |   |  |   |  |  |  |  |  |   |  |
|--|--|--|---|--|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Edith L. Burkman   |  |   |  | 2. Date of Death<br>Month Day Year<br>March 3 1997  |  |  |  | 3. Time of Death<br>7:40 PM  |  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>4125 Doris Ave.  |  |   |  | 4b. City, Town, or Location of Death<br>Brooklyn  |  |  |  | 4c. County of Death<br>Anne Arundel  |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>219-01-2286   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>95 Yrs.   |  | If Under 1 Year<br>Months Days Hours Min.              |  | 6. Date of Birth (Month, Day, Year)<br>Jan. 24, 1902   |  | 9. Birthplace (State or Foreign Country)<br>Indiana |  |
|  | Usual Residence of Decedent  |  |   |  |   |  |  |  |  |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland   |  | 10b. County<br>Anne Arundel   |  | 10c. City, Town or Location<br>Glen Burnie  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |   |  |
|  | 10e. Street and Number<br>424 Maple Lane N.W.  |  |   |  | 10f. Zip Code<br>21061  |  |  |  | 10g. Citizen of What Country?<br>United States   |  |   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 4<br>College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Meat Wrapper   |  |  |  | 16b. Kind of Business/Industry<br>Supermarket  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br>William Delbert Nuttle  |  |   |  | 16. Mother's Name (First, Middle, Maiden Surname)<br>Addie Del Miller   |  |  |  |  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Isabelle Willis/Daughter   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4125 Doris Ave. Brooklyn Park, MD 21225  |  |  |  |  |  |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Glen Haven Mem. Pk.   |  | Date<br>March 7, 1997   |  | 20c. Location - City or Town, State<br>Glen Burnie, MD |  |  |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br>Kirkley-Ruddick Funeral Home<br>421 Crain Hwy. S.E. Glen Burnie, MD 21061   |  |  |  |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Congestive Heart Failure<br>Dua to (or as a consequence of):<br><br>b.<br>Dua to (or as a consequence of):<br><br>c.<br>Dua to (or as a consequence of):<br><br>d.<br>Dua to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br>several years |  |   |  |   |  |  |  |  |  |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  |  |  |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |   |  |   |  |  |  |  |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |  |   |  |  |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |  |   |  |  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |  |   |  |  |  |  |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |   |  |   |  |  |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |  |   |  |   |  |  |  |  |  |   |  |
| 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |  |   |  |  |  |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |   |  |  |  |  |  |   |  |
| 29b. Signature and title of certifier<br>  |  |  |   |  |   |  |  |  |  |  |   |  |
| 29c. License number<br>D-40521   |  |  |   |  |   |  |  |  |  |  |   |  |
| 29d. Date signed (Month, Day, Year)<br>March 4, 1997   |  |  |   |  |   |  |  |  |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. Mahesh O'Chaney 7845 Oakwood Rd. Glen Burnie, MD 21061 Suite 205   |  |  |   |  |   |  |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>MAR 04 1997   |  |  |   |  |   |  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06233

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

|  |  |  |                                |                                    |
|--|--|--|--------------------------------|------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><i>Thelma Ballengee</i>                                |  | 2. Date of Death<br>Month <i>MARCH</i> Day <i>2</i> Year <i>1997</i> |                                | 3. Time of Death<br><i>1:40 AM</i> |
| 4a. Facility Name (If not institution, give street and number)<br><i>Maryland General Hospital</i> |  | 4b. City, Town, or Location of Death<br><i>Baltimore City</i>        |                                | 4c. County of Death<br><i>N/A</i>  |
| 5. Social Security Number<br><i>217 58 2063</i>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (If yrs. last birthday)<br><i>81</i> Yrs.                     | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.     |
| 8. Date of Birth (Month, Day, Year)<br><i>July 14, 1915</i>  |  | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i>          |                                |                                    |

Funeral  
Director

To Be Completed by Funeral Director

|   |  |   |  |  |   |  |
|---|--|---|--|--|---|--|
| Usual Residence of Decedent   |  | 10a. State<br><i>Maryland</i>   |  | 10b. County<br><i>N/A</i>  | 10c. City, Town or Location<br><i>Baltimore City</i>              | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number<br><i>Deaton Speciality Hospital<br/>611 S. Charles Street</i>   |  | 10f. Zip Code<br><i>21230</i>   |  | 10g. Citizen of What Country?<br><i>U.S.</i>   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>                        |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>6th</i> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Home Maker</i>                    |  | 16b. Kind of Business/Industry<br><i>Own Home</i>  |   |  |
| 17. Father's Name (First, Middle, Last)<br><i>Albert Johnson</i>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Edna Kolbe</i> |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>John Johnson</i>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>158 Tara Lane Haines City, Florida 33844</i>  |  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Metro Crematory, Inc.</i>  |  | Date<br><i>3/5/97</i>  | 20c. Location - City or Town, State<br><i>Baltimore, Maryland</i> |  |
| 21. Signature of Funeral Service Licensee<br><i>Danuta Znamkowski</i>   |  | 22. Name and Address of Facility<br><i>Gonce Funeral Home P.A.<br/>4001 Ritchie Highway Baltimore, Md. 21225</i>                                  |  |  |   |  |

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

|   |  |  |  |
|---|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br><i>a. Aspiration PNEUMONIA</i><br>Due to (or as a consequence of):<br><i>b. Respiratory FAILURE</i><br>Due to (or as a consequence of):<br><i>c. ACUTE RENAL FAILURE</i><br>Due to (or as a consequence of):<br><i>d.</i> |  | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 26. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 27. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |
| 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><i>M</i>  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
| 29b. Signature and title of certifier<br><i>Kenneth Chen, MD</i>  |  | 29c. License number<br><i>89271</i>  | 29d. Date signed (Month, Day, Year)<br><i>MARCH 3, 1997</i>                      |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Kenneth Chen, MD c/o Maryland General Hospital</i>   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>MAR 04 1997</i>   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  |

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

8



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06234

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES ARTHUR BRAHAM

2. Date of Death

28 97

3. Time of Death

1:30 pm

4a. Facility Name (If not institution, give street and number)

CROMWELL CENTER ELDER CARE

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

214504543

6. Sex

101 M 20 F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAR 12, 1949

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

5902 LACLEDGE RD.

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3 YRS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NURSING ASSISTANT

16b. Kind of Business/Industry

Nursing Home

17. Father's Name (First, Middle, Last)

JAMES A. BRAHAM

18. Mother's Name (First, Middle, Maiden Surname)

VERNETA COCHRAN

19a. Informant's Name/Relationship (Type, Print)

YVONNE BRAHAM

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1719 N. COLLINGTON AVE. BALTIMORE, MD 21213

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison-Forest

Date

3/7/97

20c. Location - City or Town, State

CUMMINGS MILLS

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

GARY P. MARCH FUNERAL HOME P.A.  
270 FREDERICK PASS BALTIMORE, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide  
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

DA1501

29d. Date signed (Month, Day, Year)

2/28/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

[Signature]

31. Date filed (Month, Day, Year)

MAR 04 1997

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06235

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Otis Billingsley

2. Date of Death

Month

Day

Year

February

26

1997

3. Time of Death

0531

4a. Facility Name (If not institution, give street and number)

MERCY HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

422-38-8391

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

FEB. 17 1933

9. Birthplace (State or Foreign Country)

ALABAMA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

124 W. FRANKLIN STREET APT. 413

10f. Zip Code

21201

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8th grade

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

SELF

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19e. Informant's Name/Relationship (Type, Print)

Diane Smith/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3224 Westmont Avenue, Baltimore, Maryland 21216

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. ZION CEMETERY

Date

3-1-97

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

H. G. Close

22. Name and Address of Facility

WILLIAM C. BROWN COMMUNITY F/H

1206 W. NORTH AVENUE

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Severe Sepsis

Due to (or as a consequence of):

Malignant Thymoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

days

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

constrictive cardiomyopathy, atrial fibrillation, chronic obstructive pulmonary disease, Acute myocardial infarction

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

H. G. Close

29c. License number

D37790

29d. Date signed (Month, Day, Year)

February 26, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Nervin W Todd M.D. 301 St. Paul Place Baltimore

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

J. E. Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1000 1000 1000

1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

MAR 04 1957

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 06236

Reg. No.

|  |  |                                 |   |   |  |   |  |  |
|--|--|---------------------------------|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM JAMES BUZBY</b>   |                                 |   |   | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>27</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>10:15PM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>GREATER BALTIMORE MEDICAL CENTER</b>  |                                 |   |   | 4b. City, Town, or Location of Death<br><b>TOWSON</b>  |   | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-03-5418</b>  |                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>March 26, 1913 Maryland</b>  |  |
|  | 10a. State<br><b>Maryland</b>  |                                 | 10b. County<br><b>Baltimore County</b>  |   | 10c. City, Town or Location<br><b>Baltimore</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Funeral Director  | 10e. Street and Number<br><b>52 Stevenson Lane</b>   |                                 |   |   | 10f. Zip Code<br><b>21212</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 yrs</b> Collage (1-4 or 5+)   |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Labor Representative</b>          |   | 16b. Kind of Business/Industry<br><b>Construction</b>  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>William Peter Luskin</b>   |                                 |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Emily Biles</b>  |   |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Mary Mayo Buzby (Wife)</b>   |                                 |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>52 Stevenson Lane, Baltimore, Maryland 21212</b>   |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Moreland Memorial Park</b>   |   | 20c. Date<br><b>3/3/97</b>   |   | 20d. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Martin D. Lawson</i>   |                                 | 22. Name and Address of Facility<br><b>Mitchell-Wiedefeld Home</b><br><b>6500 York Road, Baltimore, Maryland 21212</b>                            |   |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>SARCOMA, metastatic</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |                                 |   |   |  |   |  |  |
| State<br>Registrar   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive heart failure</b>  |                                 |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |                                 |   |   |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |                                 |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                 |   |   |  |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |                                 |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  |   |  |  |
| 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b> |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred                     |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |                                 |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                 |   |   |  |   |  |  |
| 29b. Signature and title of certifier<br><i>James H. [Signature]</i>   |  |                                 |   | 29c. License number<br><b>15761</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2/28/97</b> |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>James Gibson and 7401 Osler Dr, Balto, md 21204</b>   |  |                                 |   |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>  |  |                                 |   | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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9

MAR 4 1957

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06237

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Doris E. Bocklage

2. Date of Death

March 2, 1997

3. Time of Death

7:30am

4a. Facility Name (If not institution, give street and number)

322 Carroll Island Road

4b. City, Town, or Location of Death

BowleysQuarters

4c. County of Death

Baltimore

5. Social Security Number

220-14-6757

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 10, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Bowleys Quarters

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

322 Carroll Island Road

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Carl Johns

18. Mother's Name (First, Middle, Maiden Surname)

Anna Young

19a. Informant's Name/Relationship (Type, Print)

Elizabeth Gallagher/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

322 Carroll Island Road Baltimore Md. 21220

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SacredHeartofJesus

Date

3/6/97

20c. Location - City or Town, State

Baltimore Md.

21. Signature of Funeral Service Licensee

R. Terry Connelly

22. Name and Address of Facility

Connelly Funeral Home of Essex  
300 Mace Ave. Baltimore MD. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Severe COPD

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lung Cancer - Squamous

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Howard Freeland

29c. License number

D28127

29d. Date signed (Month, Day, Year)

3-3-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard Freeland, MD 5601 Loch Raven Blvd, Balto, MD 21239

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

J. S. Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

(A)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06238

Items: 23 part I, 27, 28a, b, c, d, e, f per MEO 6-245 3/11/97 reb  
Certificate of Death

Reg. No.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>CARA ANN CORNELL  |   | 2. Date of Death<br>Month Day Year<br>FEB 26 1997   |  | 3. Time of Death<br>1843 P   |
|  | 4a. Facility Name (If not institution, give street and number)<br>ATLANTIC GENERAL HOSPITAL   |   | 4b. City, Town, or Location of Death<br>BERLIN  |  | 4c. County of Death<br>WORCESTER   |
| Funeral<br>Director  | 5. Social Security Number<br>135-56-4630  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>30 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>FEB 18, 1967      | 9. Birthplace (State or Foreign Country)<br>Pennsylvania   |
|  | Usual Residence of Decedent   |   |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>MD  | 10b. County<br>Worcester  | 10c. City, Town or Location<br>Ocean City   |  | 10d. Inside City Limits<br>Y <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|  | 10e. Street and Number<br>14307 Lighthouse Ave., Unit 102   |   | 10f. Zip Code<br>21842  |  | 10g. Citizen of What Country?<br>USA   |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:    |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (14 or 5+)                          |  |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Maid Service   |   | 16b. Kind of Business/Industry<br>Hotel Service   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Frederick Cornell  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Claramae Bauer   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Frederick Cornell/father  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>104 120th St., Unit 301 Ocean City, MD 21842 |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory, Inc. 2/27/97                                       |  | 20c. Location - City or Town, State<br>Baltimore, MD   |
|  | 21. Signature of Funeral Service Licensee<br>Dawn F. McDonald   |   | 22. Name and Address of Facility<br>Cremation Society of Maryland, Inc.<br>299 Frederick Rd. Baltimore, MD 21228                              |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. COCAINE AND NARCOTIC INTOXICATION<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |   |   |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |   |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |   |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |   |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)  |   |   |   |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input checked="" type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)<br>2/26/97   |   |  |  |
| 28b. Time of Injury<br>5:52 P. M   |   | 28c. Injury et Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                       |   | 28d. Describe how Injury occurred<br>Unknown             |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>Found in house   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>14307 Lighthouse Ave. Ocean City, Md. |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |  |
| 29b. Signature and title of certifier<br>Theodore M. King  |   | 29c. License number<br>O.C.M.E  |   | 29d. Date signed (Month, Day, Year)<br>FEBRUARY 27, 1997 |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201  |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 04 1997   |   | 32. Registrar's Signature<br>J. M. Anderson-Randall   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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/Medical  
Examiner

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Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06239

## Certificate of Death

Reg. No.

|  |  |             |   |   |   |  |                                |  |   |  |   |   |   |  |
|--|--|-------------|---|---|---|--|--------------------------------|--|---|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>EDNA C. CARSON</b>                                  |             |   |   | 2. Date of Death<br>Month <b>2</b> Day <b>26</b> Year <b>97</b> |  |                                |  | 3. Time of Death<br><b>10:34 AM</b>   |  |   |   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Maryland General Hospital</b> |             |   |   | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>   |  |                                |  | 4c. County of Death<br><b>N/A</b>   |  |   |   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-01-8519</b>  |             | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.                |  | If Under 1 Year<br>Months Days |  | If Under 24 Hrs.<br>Hours Min.  |  | 8. Date of Birth (Month, Day, Year)<br><b>AUGUST 29, 1911</b> |   | 9. Birthplace (State or Foreign Country)<br><b>NORTH CAROLINA</b> |  |
|  | Usual Residence of Decedent  |             |   |   |   |  |                                |  |   |  |   |   |   |  |
| 10a. State<br><b>MARYLAND</b>  |  | 10b. County |   | 10c. City, Town or Location<br><b>BALTIMORE</b>   |   |  |                                |  |   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
| 10e. Street and Number<br><b>1611 LORMAN AVE, (COURT)</b>  |  |             |   | 10f. Zip Code<br><b>21217</b>   |   |  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |   |   |   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>AFRO.AMERICAN</b> |  |   |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)   |  |             |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>BLUEFIELD CATERERS</b>  |   |  |                                | 16b. Kind of Business/Industry<br><b>WAITERS</b>                                     |   |  |   |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>LONNIE MORRIS</b>  |  |             |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>HAZEL DALTON</b>   |                                |  |   |  |   |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ESTHER C. PURNELL</b>   |  |             |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3914 GREENSPRING AVE, BALTIMORE, MARYLAND 21215</b>                                      |                                |  |   |  |   |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |             |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>WOODLAWN CEMETERY</b>  |   | Date<br><b>3/3/97</b>  |                                | 20c. Location - City or Town, State<br><b>BALTIMORE, MARYLAND</b>                    |   |  |   |   |   |  |
| 21. Signature of Funeral Service Licensee<br>  |  |             |   |   |   | 22. Name and Address of Facility<br><b>ESTEP BROTHERS FUNERAL HOME, P.A.<br/>1300 EUTAW PLACE, BALTIMORE, MD. 21217</b>  |                                |  |   |  |   |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>ACUTE MYOCARDIAL INFARCTION.</b><br>Due to (or as a consequence of):<br>b. <b>CHRONIC RENAL FAILURE</b><br>Due to (or as a consequence of):<br>c. <b>THROMBOCYTOPENIA.</b><br>Due to (or as a consequence of):<br>d. |  |             |   |   |   |  |                                |  |   |  |   | Approximate Interval Between Onset and Death  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |             |   |   |   |  |                                |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |   |   |  |
|  |  |             |   |   |   |  |                                |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |             |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |                                |  |   |  |   |   |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |             |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |   |   |   |  |
|  |  |             |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |   |  |   |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |             |   |   |   |  |                                |  |   |  |   |   |   |  |
| 29b. Signature and title of certifier<br><b>Khuram A. Butt Intern</b>  |  |             |   |   |   | 29c. License number<br><b>89267</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>2/26/97</b>                                |   |  |   |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Khuram Butt, M.D. 40 Maryland General Hospital</b>  |  |             |   |   |   |  |                                |  |   |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>  |  |             |   | 32. Registrar's Signature<br>  |   |  |                                |  |   |  |   |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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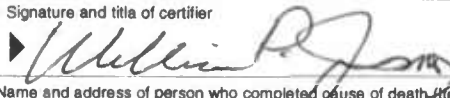
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06240

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |                                |  |  |                                   |
|--|--|--|---|--|--|--------------------------------|--|--|-----------------------------------|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Raymond Alvin Crandall</b>  |  |   |  | 2. Date of Death<br>Month <b>Feb</b> Day <b>25</b> Year <b>1997</b>  |                                | 3. Time of Death<br><b>1029</b>  |  |                                   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>7410 Baltimore Annapolis Boulevard</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>   |                                | 4c. County of Death<br><b>AA</b>   |  |                                   |
| Funeral<br>Director  | 5. Social Security Number<br><b>216 28 7010</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 13, 1933</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |                                   |
|  | Usual Residence of Decedent  |  |   |  |  |                                |  |  |                                   |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Glen Burnie</b>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |                                   |
|  | 10e. Street and Number<br><b>7410 Baltimore Annapolis Blvd.</b>  |  |   |  | 10f. Zip Code<br><b>21061</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.</b>   |  |                                   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Korean Conflict</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |                                   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Plumber</b>   |  | 16b. Kind of Business/Industry<br><b>Union</b>   |                                |  |  |                                   |
| To Be Completed by Physician/Medical Examiner                        | 17. Father's Name (First, Middle, Last)<br><b>Charles Albert Crandall</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Adelaide Townsend</b>  |                                |  |  |                                   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Elizabeth A. Criss / daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5913 Manorhouse Lane Baltimore, Maryland 21225</b>                                       |                                |  |  |                                   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Md. State Veteran Cem.</b>   |  | Date<br><b>2/28/97</b>   |                                | 20c. Location - City or Town, State<br><b>Crownsville, Maryland</b>                            |  |                                   |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Gonce Funeral Home P.A.<br/>4001 Ritchie Highway Baltimore, Md. 21225</b>   |                                |  |  |                                   |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Acute Cardiac Insufficiency</b><br>Due to (or as a consequence of):<br>b. <b>Arteriosclerotic Heart Disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |                                |  | Approximate Interval Between Onset and Death<br><b>UNK</b>   |                                   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b>  |  |   |  |  |                                |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                   |
|  |  |  |   |  |  |                                |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                   |
|  |  |  |   |  |  |                                |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                                   |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |  |  |                                   |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |  | 28d. Describe how injury occurred |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |                                |  |  |                                   |
|  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |                                |  |  |                                   |
| State Registrar  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br> Deputy   |  | 29c. License number<br><b>D 06054</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>2-25-1997</b>  |  |                                   |
|  | 30. Name and address of person who completed cause of death (from 23a) (Type, Print)<br><b>William P. Jones, M.D. 695 America Court 21035</b>  |  |   |  |  |                                |  |  |                                   |
|  | 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>  |  | 32. Registrar's Signature<br>  |  |  |                                |  |  |                                   |
|  |  |  |   |  |  |                                |  |  |                                   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Autopsy Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Week 11: 11/11/11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06241

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH EDWARD COLLERAN JR.

2. Date of Death

FEBRUARY 27, 1997

3. Time of Death

4:45 A.M.

4a. Facility Name (If not institution, give street and number)

702 ELMWOOD ROAD

4b. City, Town, or Location of Death

BALTIMORE COUNTY

4c. County of Death

BALTIMORE

5. Social Security Number

216-56-4446

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAY 4, 1952

9. Birthplace (State or Foreign Country)

BALTIMORE, MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE COUNTY

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

702 ELMWOOD ROAD

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ASSISTANT MANAGER

16b. Kind of Business/Industry

SUPER FRESH FOOD MARKET

17. Father's Name (First, Middle, Last)

JOSEPH EDWARD COLLERAN SR.

18. Mother's Name (First, Middle, Maiden Surname)

MARY ELLEN EVERT

19a. Informant's Name/Relationship (Type, Print)

BARBARA A. COLLERAN (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

702 ELMWOOD ROAD BALTIMORE, MARYLAND 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PARKWOOD CEMETERY MARCH 3, 1997

Date

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

*Blather Bessie Bessie*

22. Name and Address of Facility

LASSAHN FUNERAL HOME, INC.

7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

18 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Paul Celano, M.D.*

29c. License number

D30929

29d. Date signed (Month, Day, Year)

2/28/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PAUL CELANO, M.D. 656 N. Charles St, BALTIMORE, MD 21204

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

*John Davidson-Randall*State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

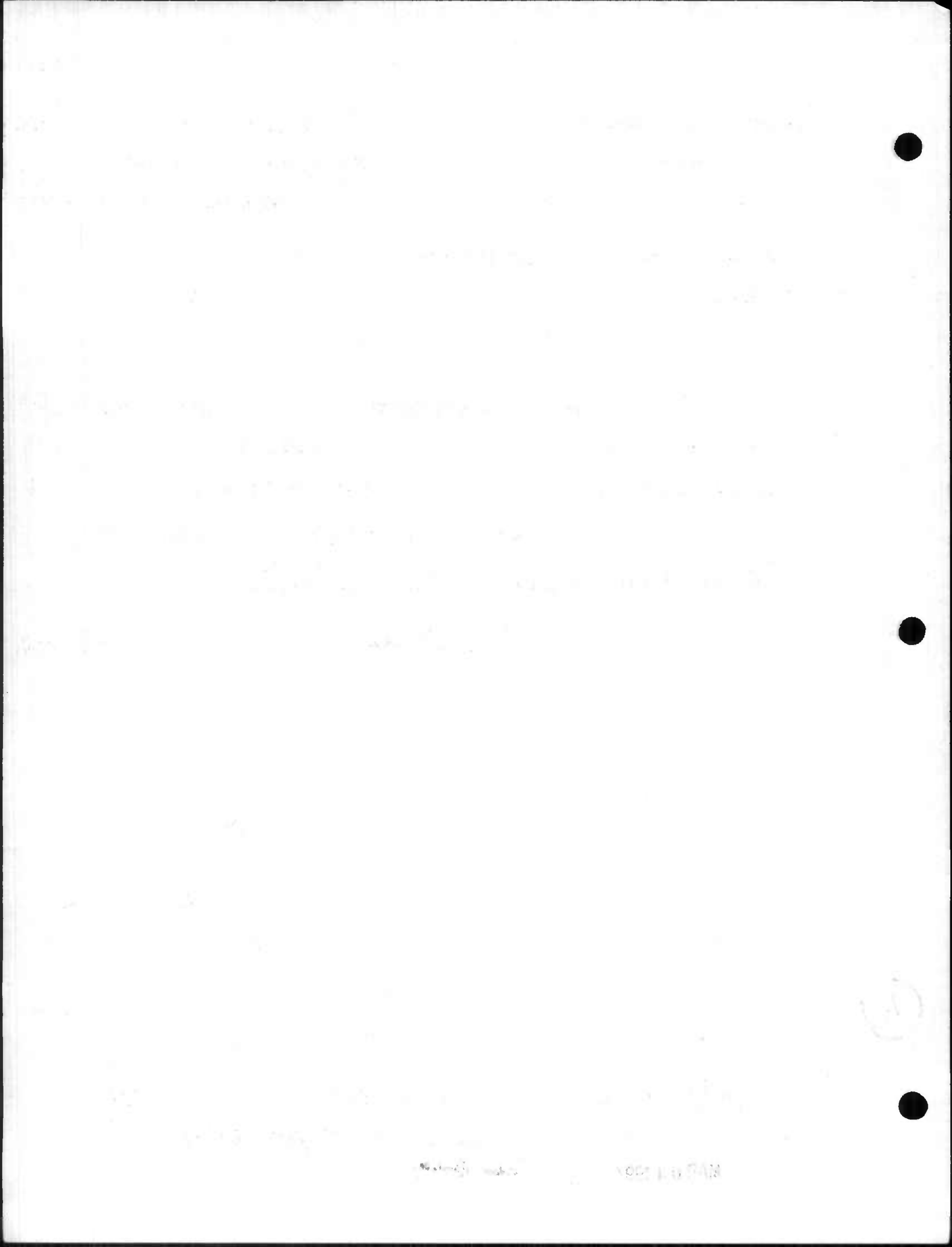
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or the attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06242

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edith N. Carter

2. Date of Death

Month  
MarchDay  
1,Year  
1997

3. Time of Death

6:50 PM

4a. Facility Name (If not institution, give street and number)

844 Powers Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

212-12-2471

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept 8, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

844 Powers Street

10f. Zip Code

21211

10g. Citizen of What Country?

U.S.A

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Salesperson

16b. Kind of Business/Industry

New System Bakery

17. Father's Name (First, Middle, Last)

Clarence Cromwell

18. Mother's Name (First, Middle, Maiden Surname)

Eva Heavel

19a. Informant's Name/Relationship (Type, Print)

James Y. Carter (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

844 Powers Street, Baltimore, Maryland 21211

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lake View Mem Park

Date

3/4/95

20c. Location - City or Town, State

Sykesville, Maryland

21. Signature of Funeral Service Licensee

A. Alan Seitz, Jr.

22. Name and Address of Facility

A. Alan Seitz, Jr. Funeral Home

3818 Roland Avenue, Baltimore, Maryland 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ENDOMETRIAL CANCER, METASTATIC 8 MONTHS

Due to (or as a consequence of):

b. HYPOKIA DUE TO PULMONARY INVOLVEMENT 3 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOAOther: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph Buscema, MD

29c. License number

225274

29d. Date signed (Month, Day, Year)

MARCH 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH BUSCEMA MD 6569 NORTH CHARLES ST, SUITE 7H, BALTIMORE, MD 21204

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

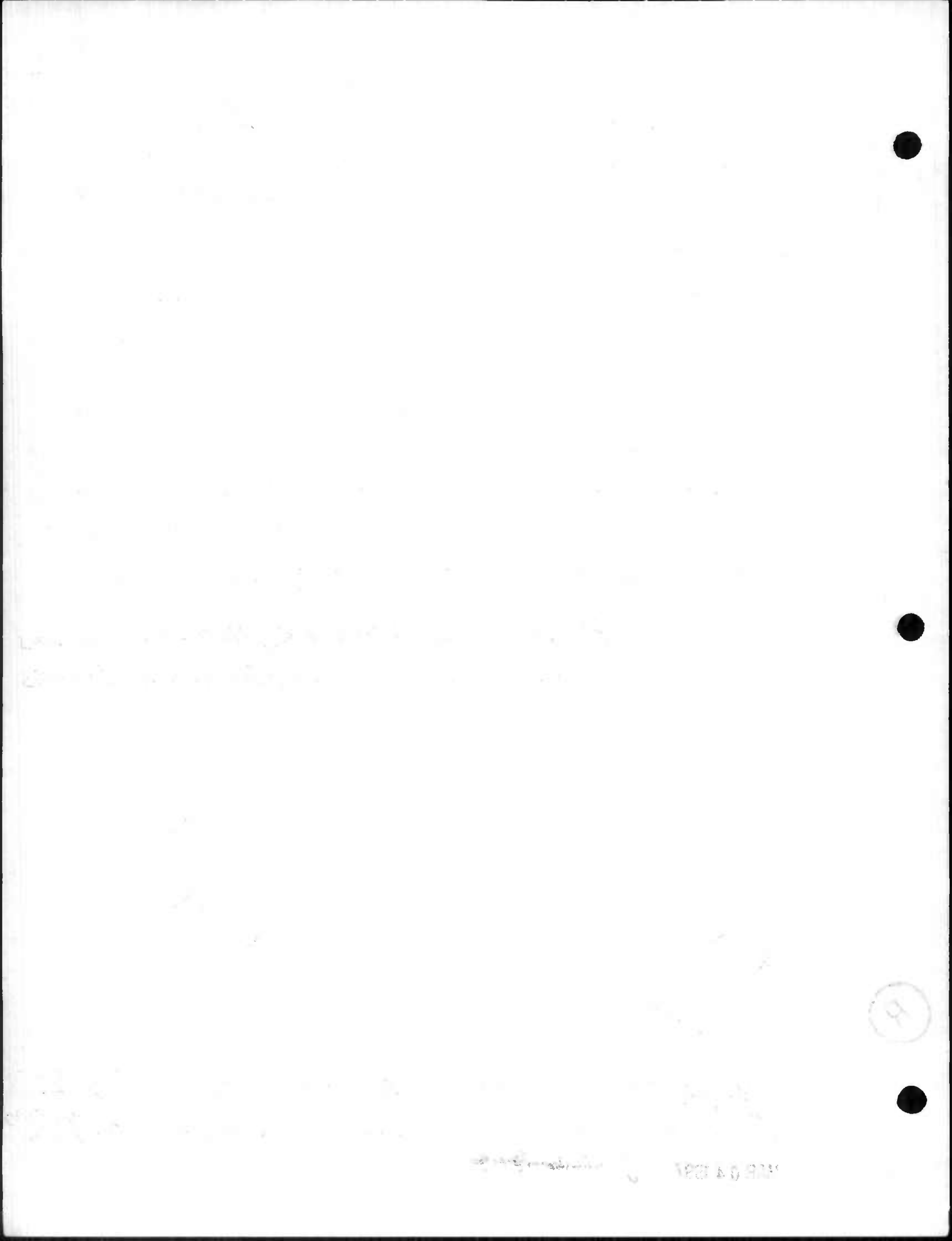
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06243

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |   |  |
|---|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedant's Name (First, Middle, Last)<br><b>ROBERT JOSEPH CLAY</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 3, 1997</b>   |  | 3. Time of Death<br><b>3 AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>IVY HALL NURSING CENTER</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>MIDDLE RIVER</b>  |  | 4c. County of Death<br><b>BALTIMORE</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>219106250</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 16, 1926</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>BALTIMORE</b>  |  | 10c. City, Town or Location<br><b>BLACKTHORNE</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>5717 VAN DYKE ROAD</b>   |  | 10f. Zip Code<br><b>21206</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedant Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b>  |  | 13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedant's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>   |  | Collage (1-4 or 5+) <b>0</b>  |  | 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LETTER CARRIER</b>   |  | 16b. Kind of Business/Industry<br><b>POST OFFICE</b>  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>EDWIN CLAY</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MADELINE WACHTER</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>WANDA CLAY / WIFE</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5717 VAN DYKE ROAD BALTIMORE, MD 21206</b>   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GARDENS OF FAITH</b>   |  | 20c. Date<br><b>3/6/97</b>   |  | 20d. Location - City or Town, State<br><b>BALTIMORE, MD</b>   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>CVACH/ROSEDALE FUNERAL HOME</b><br><b>1211 CHESACO AVE 21237</b>  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Possible Acute MI</b><br>Due to (or as a consequence of):<br><br>b. <b>of Decedent</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><b>1 Day</b><br><b>2+ yrs.</b> |  |   |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |  |
|   |  |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D14221</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3.3.97</b>  |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>T. A. Fikow 223 E. Blvd BALT MD 21241</b>   |  |   |  |  |  |   |  |
|   | 31. Date filed<br><b>MARCH 4 1997</b>  |  | 32. Registrar's Signature<br>   |  |  |  |   |  |

101

3

120 20 200

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06244

## Certificate of Death

Reg. No.

|   |  |   |  |   |  |   |  |  |
|---|--|---|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Benjamin Z. CRENSHAW</b>                                  |   |  |   | 2. Date of Death<br>Month <b>March</b> Day <b>2</b> Year <b>1997</b> |   | 3. Time of Death<br><b>12:50 PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital Center</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Rosedale</b>              |   | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>215034824</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                   | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  | If Under 1 Year<br>Months Days                                       | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>July 25, 1917</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>VIRGINIA</b>  |
|   | Usual Residence of Decedent  |   |  |   |  |   |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>ROSEDALE</b>  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>1231 LANDOVER ROAD</b>   |  |   |  | 10f. Zip Code<br><b>21237</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ROAD DRIVER</b>   |  |   | 18b. Kind of Business/Industry<br><b>MOVING CO.</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>CHARLES EVANS CRENSHAW</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MAUDE ADA McCAULEY</b>  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>RUTH E. CRENSHAW / WIFE</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1231 LANDOVER ROAD ROSEDALE, MD 21237</b>   |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HOLLY HILLS</b> |   | Date<br><b>3/5/97</b>  | 20c. Location - City or Town, State<br><b>MIDDLE RIVER, MD</b>                              |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>CVACH/ROSEDALE FUNERAL HOME</b><br><b>1211 CHESACO AVE 21237</b>   |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |   |  |   |  | Approximate Interval Between Onset and Death   |
| Immediate Cause (Final disease or condition resulting in death)   |  |   |  |   |  |   |  | 24 Hours   |
| a. <u>Sepsis</u><br>Due to (or as a consequence of):  |  |   |  |   |  |   |  | 24 Hours   |
| b. <u>Rhabdomyolysis</u><br>Due to (or as a consequence of):  |  |   |  |   |  |   |  | 13 Years   |
| c. <u>Alcoholic Cirrhosis</u><br>Due to (or as a consequence of):   |  |   |  |   |  |   |  | 6 Hours  |
| d. <u>Gastrointestinal Bleeding</u>   |  |   |  |   |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |   |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| Colon Cancer Resected 1985  |  |   |  |   |  |   |  |  |
| Senile Dementia   |  |   |  |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|   |  |   |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 28a. Date of Injury (Month, Day Year)   |  |   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |   |  |   |  |  |
| 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>RD 2103</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3-3-97</b>  |  |  |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>Nicola Hesse MD. 9000 Franklin Square Dr. Balto, Md. 21237</b>   |  |   |  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>   |  |   |  | 32. Registrar's Signature<br>   |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that this certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be attached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the document is a list of names and addresses of the members of the committee. The names are listed in alphabetical order, and the addresses are given in full. The list is as follows:

Mr. J. H. Smith, 123 Main St., New York, N. Y.  
Mr. J. D. Jones, 456 Elm St., Boston, Mass.  
Mr. W. E. Brown, 789 Oak St., Chicago, Ill.  
Mr. R. L. Green, 101 Pine St., Philadelphia, Pa.  
Mr. S. K. White, 202 Cedar St., St. Louis, Mo.  
Mr. T. M. Black, 303 Maple St., Cincinnati, Ohio.  
Mr. U. N. Gray, 404 Birch St., Portland, Me.  
Mr. V. O. Hall, 505 Spruce St., Seattle, Wash.  
Mr. W. P. King, 606 Fir St., San Francisco, Cal.  
Mr. X. Q. Lee, 707 Ash St., Los Angeles, Cal.  
Mr. Y. R. Scott, 808 Hickory St., Denver, Colo.  
Mr. Z. S. Adams, 909 Walnut St., Salt Lake City, Utah.  
Mr. A. T. Baker, 1010 Chestnut St., San Diego, Cal.  
Mr. B. U. Carter, 1111 Olive St., Albuquerque, N. M.  
Mr. C. V. Evans, 1212 Elm St., Santa Fe, N. M.  
Mr. D. W. Foster, 1313 Oak St., Las Vegas, Nev.  
Mr. E. X. Gibson, 1414 Pine St., Reno, Nev.  
Mr. F. Y. Harris, 1515 Cedar St., Carson City, Nev.  
Mr. G. Z. Ingram, 1616 Maple St., Elko, Nev.  
Mr. H. A. Jackson, 1717 Birch St., Winnemucca, Nev.  
Mr. I. B. Keller, 1818 Spruce St., Gardnerville, Nev.  
Mr. J. C. Lewis, 1919 Fir St., Sparks, Nev.  
Mr. K. D. Martin, 2020 Ash St., Reno, Nev.  
Mr. L. E. Nelson, 2121 Hickory St., Carson City, Nev.  
Mr. M. F. Owen, 2222 Walnut St., Reno, Nev.  
Mr. N. G. Parker, 2323 Chestnut St., Sparks, Nev.  
Mr. O. H. Quinn, 2424 Olive St., Carson City, Nev.  
Mr. P. I. Roberts, 2525 Elm St., Reno, Nev.  
Mr. Q. J. Scott, 2626 Oak St., Sparks, Nev.  
Mr. R. K. Taylor, 2727 Pine St., Carson City, Nev.  
Mr. S. L. Vance, 2828 Cedar St., Reno, Nev.  
Mr. T. M. Ward, 2929 Maple St., Sparks, Nev.  
Mr. U. N. Webb, 3030 Birch St., Carson City, Nev.  
Mr. V. O. White, 3131 Spruce St., Reno, Nev.  
Mr. W. P. Wilson, 3232 Fir St., Sparks, Nev.  
Mr. X. Q. Young, 3333 Ash St., Carson City, Nev.  
Mr. Y. R. Ziegler, 3434 Hickory St., Reno, Nev.  
Mr. Z. S. Zimmerman, 3535 Walnut St., Sparks, Nev.

THE COMMITTEE ON THE  
MOUNTAIN STATES

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06245

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George Dimler

2. Date of Death

February 25 1997

3. Time of Death

2:55am.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Dorchester General Hospital

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

220-14-5172

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APR. 16, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1433 Decatur St.

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Navar Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

3

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Grounds Keeper

16b. Kind of Business/Industry

Baltimore City

17. Father's Name (First, Middle, Last)

George Dimeler

18. Mother's Name (First, Middle, Maiden Sumame)

Bridget Fogarty

19a. Informant's Name/Relationship (Type, Print)

Joan Wheat - cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1433 Decatur Street, Baltimore, Md. 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial Pk.

Date

2/28/97

20c. Location - City or Town, State

Elkridge, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gary L. Kaufman Funeral Home at Meadowridge  
7250 Washington Blvd., Elkridge, Md. 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Coronary Heart Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 wks.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Atherosclerotic Heart Disease

Due to (or as a consequence of):

5 yrs

Peripheral Vascular Disease

Due to (or as a consequence of):

1 1/2 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Seizure disorder  
Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michael Fadden MD

29c. License number

P26388

29d. Date signed (Month, Day, Year)

02-25-1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Fadden MD 302 Collins Hurlock Md 21643

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

Julia Davidson-Pandolfi

State  
Registrar

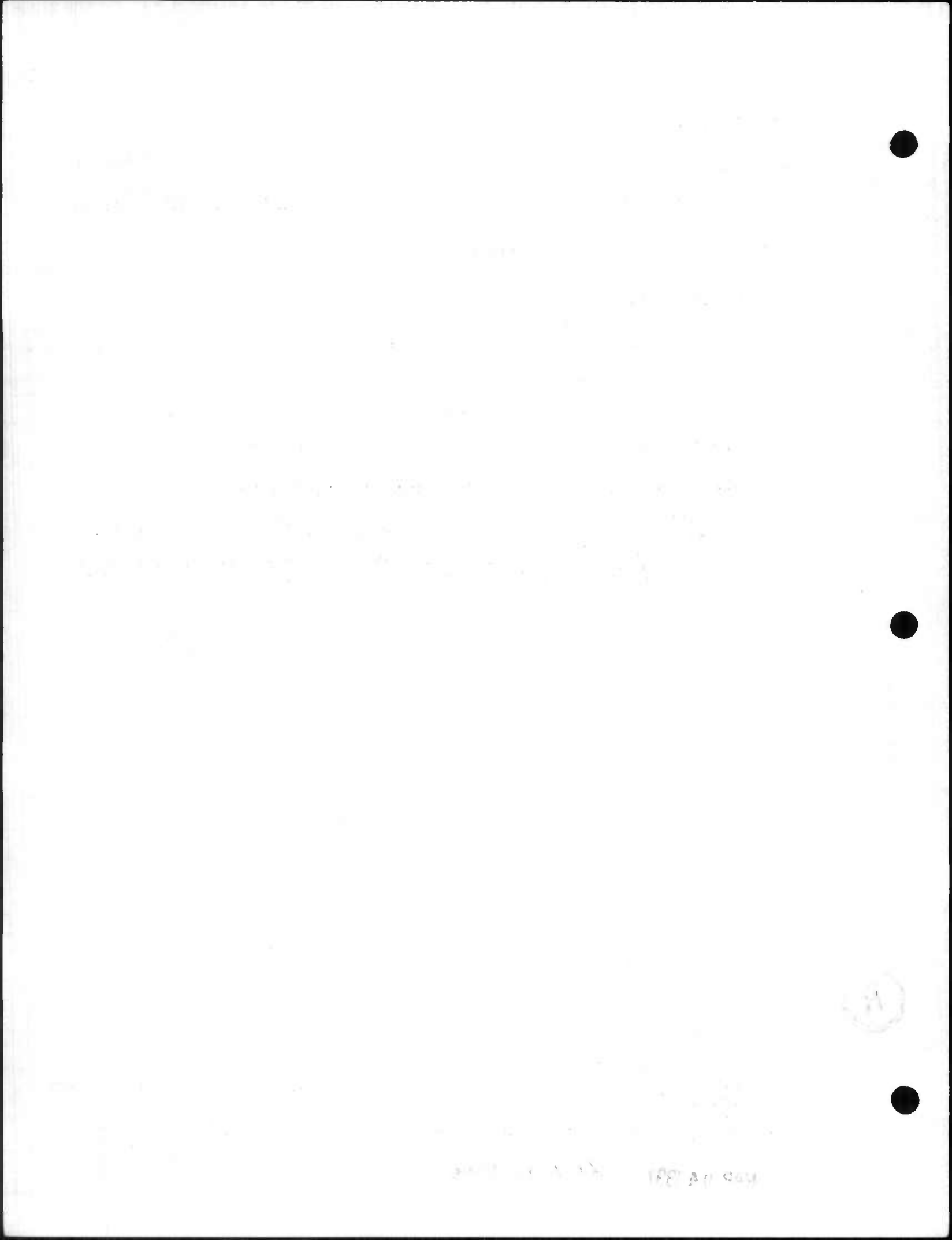
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or attending Physician: The law requires that the death certificate be executed within 24 hours of death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner





97 06246

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Paul Fuller DuVivier</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 27, 1997</b>  |  | 3. TIME OF DEATH<br><b>11:12 a m</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>537-07-8602</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>02-04-1915</b>                                 |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>BROADMEADE RETIREMENT COMMUNITY</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>COCKEYSVILLE</b>  |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>   |   |
| 10a. STATE<br><b>MARYLAND</b>  |  |  |  | 10b. COUNTY<br><b>BALTIMORE</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>COCKEYSVILLE</b>  |   |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>13801 YORK RD.</b>   |  |   |   |
| 10f. ZIP CODE<br><b>21030</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>5+</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>DIPLOMAT</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>STATE DEPARTMENT</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOSEPH DuVivier</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ELEANOR KEYES</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARGARET DuVivier (wife)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13801 YORK RD. COCKEYSVILLE, MD. 21030.</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>OAK HILL CEMETERY 03/07/97</b>   |  | 20c. LOCATION — City or Town, State<br><b>GEORGETOWN, D.C.</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>William R. Barrett</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HENRY W. JENKINS &amp; SONS CO.<br/>4905 YORK RD. BALTO., MD. 21212.</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. SMALL CELL CARCINOMA OF COLON</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>3 mo.</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>LIVER METASTASES</b><br><b>PROSTATE CANCER</b><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><b>NIA</b> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Barbara Carroll, MD</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D38392</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/27/97</b>                                       |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>BARBARA CARROLL, M.D. 13801 YORK RD., COCKEYSVILLE, MD</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 04 1997</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>John H. ...</i>  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been filed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 states any injury, or other traumatic event, the medical examiner must be notified at once.

1954-1955

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 29e,f Film G745 Per ME 3-4-97 rja

## Certificate of Death

97 06247

Reg. No.

|   |   |  |  |   |  |   |   |  |
|---|---|--|--|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>KEVIN DOMNEYS</b>  |  |  |   | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 28, 1997</b>   |   | 3. Time of Death<br><b>2340PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>4800 BLOCK CLAYBURY AVENUE</b>   |  |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>  |   | 4c. County of Death<br><b>N/A</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-86-4425</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>32</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>April 20, 1964</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Md.</b>  |  | 10a. State<br><b>Md.</b>   |   | 10b. County<br><b>N/A</b>  |   | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   | 10e. Street and Number<br><b>5003 Loadstone Way</b>  |   | 10f. Zip Code<br><b>21206</b>   |  |
|   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
|   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1+</b> College (1-4 or 5+)                      |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Caterer</b>   |  |  |   | 16b. Kind of Business/Industry<br><b>Holiday Inn</b>   |   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>James Domneys</b>   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Barbara Wilson</b>   |   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print) <b>mother</b>  |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3821 Fernside Rd. Randallstown, Md. 21133</b>                              |   |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King Memorial Park</b>  |   | 20c. Location - City or Town, State<br><b>March 6 Randallstown, Md.</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Tracy L. Rollins</i>  |  |  |   | 22. Name and Address of Facility<br><b>Nutter Funeral Homes, Inc.<br/>2501 Gwynns Falls PKWY Baltimore, Md. 21216</b>  |   |   |  |
|   | 23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Stab wound to chest</b> |  |  |   | Approximate Interval Between Onset and Death   |   |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b> |   |  |  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |   |   |  |
| 28a. Date of Injury (Month, Day, Year)<br><b>2/28/97</b>  |   |  |  | 28b. Time of Injury<br><b>UNK</b> M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 28d. Describe how Injury occurred<br><b>subject stabbed</b>   |   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>STREET</b>   |  |   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>4800 Block Claybury<br/>21206 Ave. Baltimore MD</b>  |   |  |  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |
| 29b. Signature and title of certifier<br><i>David L. ... MD</i>   |   |  |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 01, 1997</b>                                |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. A. ... MD</b>   |   |  |  | 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>   |  |   |   |  |
| 32. Registrar's Signature<br><i>John Davidson</i>   |   |  |  |   |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

RECEIVED

SEP 10 1955

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06248

Items: 10e, 19b per F.H. G-745 3/10/97 reb **Certificate of Death**

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Foster Davis, Senior

2. Date of Death

March 2, 1997

3. Time of Death

2:00 pm

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral  
Director

5. Social Security Number

223-58-7289

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

50

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

03/05/1946

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2506 Ruscombe Lane

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Tractor Trailer Driver

16b. Kind of Business/Industry

Bond Transfer

17. Father's Name (First, Middle, Last)

David Davis

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Shine

19a. Informant's Name/Relationship (Type, Print)

Joyce Davis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2506 Ruscombe Lane, Balto., MD 21215

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Memorial Park 3/8

Date

20c. Location - City or Town, State

Arbutus, Maryland

21. Signature of Funeral Service Licensee

Leroy O. Dyett

22. Name and Address of Facility

LEROY O. DYETT & SON FUNERAL HOME, P.A.  
4600 LIBERTY HEIGHTS AVE., BALTO. 21207

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Lung Cancer  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

one year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Clara B. Herrin MD

29c. License number

AS 2402321 CH 9001

29d. Date signed (Month, Day, Year)

March 2, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Clara B. Herrin Sinai Hospital

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

John Davidson

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

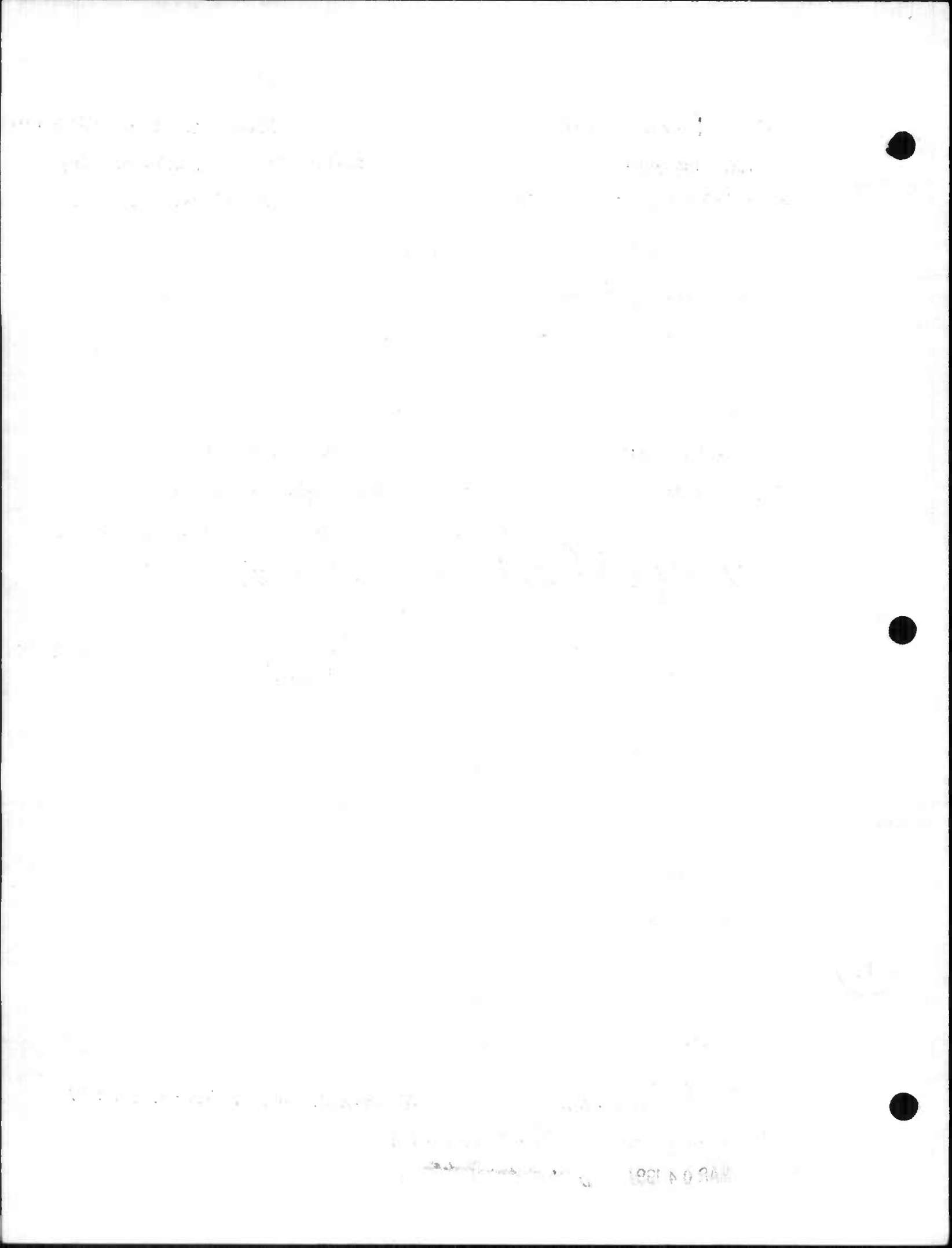
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06249

## Certificate of Death

Reg. No.

|                                     |  |  |   |  |  |  |  |  |
|-------------------------------------|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Roger L. DICKENSON   |  |   |  | 2. Date of Death<br>Month Day Year<br>February 27, 1997  |  | 3. Time of Death<br>12:10 pm   |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br>Franklin Square Hospital Center  |  |   |  | 4b. City, Town, or Location of Death<br>Rosedale   |  | 4c. County of Death<br>Baltimore   |  |
| Funeral<br>Director                 | 5. Social Security Number<br>212301384   |  | 8. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>64 Yrs.  |  | If Under 1 Year<br>Months Days   |  |
|                                     | 6. Date of Birth (Month, Day, Year)<br>NOV. 19, 1932   |  | 9. Birthplace (State or Foreign Country)<br>VIRGINIA  |  | 10. Usual Residence of Decedent  |  |  |  |
| To Be Completed by Funeral Director | 10a. State<br>MD   |  | 10b. County<br>BALTIMORE  |  | 10c. City, Town or Location<br>RASPEBURG   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|                                     | 10e. Street and Number<br>8000 LANGDON LANE  |  |   |  | 10f. Zip Code<br>21206   |  | 10g. Citizen of What Country?<br>USA   |  |
|                                     | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: KOREA   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |  |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) 0  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>LOGISTICS   |  | 16b. Kind of Business/Industry<br>FED. GOV'T   |  |
|                                     | 17. Father's Name (First, Middle, Last)<br>LAKE EARL DICKENSON   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>JESSIE FARMER   |  |  |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br>KITTY DEAN / DAUGHTER  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3706 TAKOYA DR ELLICOTT CITY, MD 21042  |  |  |  |
|                                     | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>METRO CREMATORY   |  | Data<br>3/3/97   |  | 20c. Location - City or Town, State<br>BALTIMORE, MD   |  |
|                                     | 21. Signature of Funeral Service Licensee  |  |   |  | 22. Name and Address of Facility<br>CVACH/ROSEDALE FUNERAL HOME<br>1211 CHESACO AVE 21237  |  |  |  |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Pneumococcal Sepsis<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  |
|                                     | Approximate Interval Between Onset and Death<br>96 Hours   |  |   |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Acute Renal Failure  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|                                     |  |  |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|                                     |  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|                                     | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|                                     | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|                                     | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how injury occurred  |  |  |  |
|                                     | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |  |  |
|                                     | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |
|                                     | 29b. Signature and title of certifier<br>James Orford  |  |   |  | 29c. License number<br>RD1930  |  | 29d. Date signed (Month, Day, Year)<br>February 27, 1997   |  |
|                                     | 30. Name and address of person who completed Cause of death (Item 23a) (Type, Print)<br>James Orford M.D. 9000 Franklin Square Drive Baltimore, Maryland 21237   |  |   |  |  |  |  |  |
| State<br>Registrar                  | 31. Date filed (Month, Day, Year)<br>MAR 04 1997   |  |   |  | 32. Registrar's Signature<br>James Orford  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records P.O. Box 68760,

To the Hospital or Attending Physician: The physician who certifies the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHHM 16 Rev 6/95





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06250

## Certificate of Death

Reg. No.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Marilyn DEFFINBAUGH</b>                                   |   | 2. Date of Death<br>Month <b>March</b> Day <b>1</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>3:20 PM</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital Center</b> |   | 4b. City, Town, or Location of Death<br><b>Rosedale</b>  |   | 4c. County of Death<br><b>Baltimore</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-68-3622</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>42</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 17, 1955</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   |  |
| Usual Residence of Decedent  |  |   |  |   |  |
| 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Middle River</b>  |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  |
| 10e. Street and Number<br><b>4 Randy Frost Court</b>   |  | 10f. Zip Code<br><b>21220</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>   |  | 16b. Kind of Business/Industry<br><b>own home</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>George Gephardt</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elaine Gillespie</b>   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Alfred Deffinbaugh/husband</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4 Randy Frost Court Baltimore Maryland 21220</b> |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holly Hill Cemetery</b>  |  | Date<br><b>3/5/97</b>   | 20c. Location - City or Town, State<br><b>Baltimore Md.</b>  |
| 21. Signature of Funeral Service Licensee<br><b>R. Terry Connelly</b>  |  | 22. Name and Address of Facility<br><b>Connelly Funeral Home of Essex<br/>300 Mace Ave. Baltimore Md. 21221</b>   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. <b>Pericardial Tamponade</b><br>Due to (or as a consequence of):<br><br>b. <b>Metastatic Breast Carcinoma</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of): |  |   |  |   | Approximate Interval Between Onset and Death<br><br><b>2 Days</b><br><br><b>5 Years</b>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|  |  |   |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
|  |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |  |
|  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>  |  | 29c. License number<br><b>D21846</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/1/97</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARTIN J. SHERIDAN MD 9000 Franklin Square Drive Baltimore Maryland 21237</b>   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06251

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDGAR LEE FORD

2. Date of Death

Month Day Year  
MARCH 1 1997

3. Time of Death

5:12 A.M.

4a. Facility Name (If not institution, give street and number)

Bon Secours Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

232-01-7320

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MAY 22, 1912

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2409 W. Lombard Street

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Painter

16b. Kind of Business/Industry

Residential Painting

17. Father's Name (First, Middle, Last)

Oatha Ford

18. Mother's Name (First, Middle, Maiden Surname)

Gertie Stump

19a. Informant's Name/Relationship (Type, Print)

Gertrude A. Wales / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

806 Primson Avenue Baltimore, MD 21229

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory, Inc. 03/03/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

George E. MacNabb

22. Name and Address of Facility

Cremation Society of Md., Inc.

299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D4335

29d. Date signed (Month, Day, Year)

3/1/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IKECHI FRED

OKWARA MD

4000

West

Northern Parkway

Baltimore MD

21215

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

F. K. R. R. R.

State  
Registrar

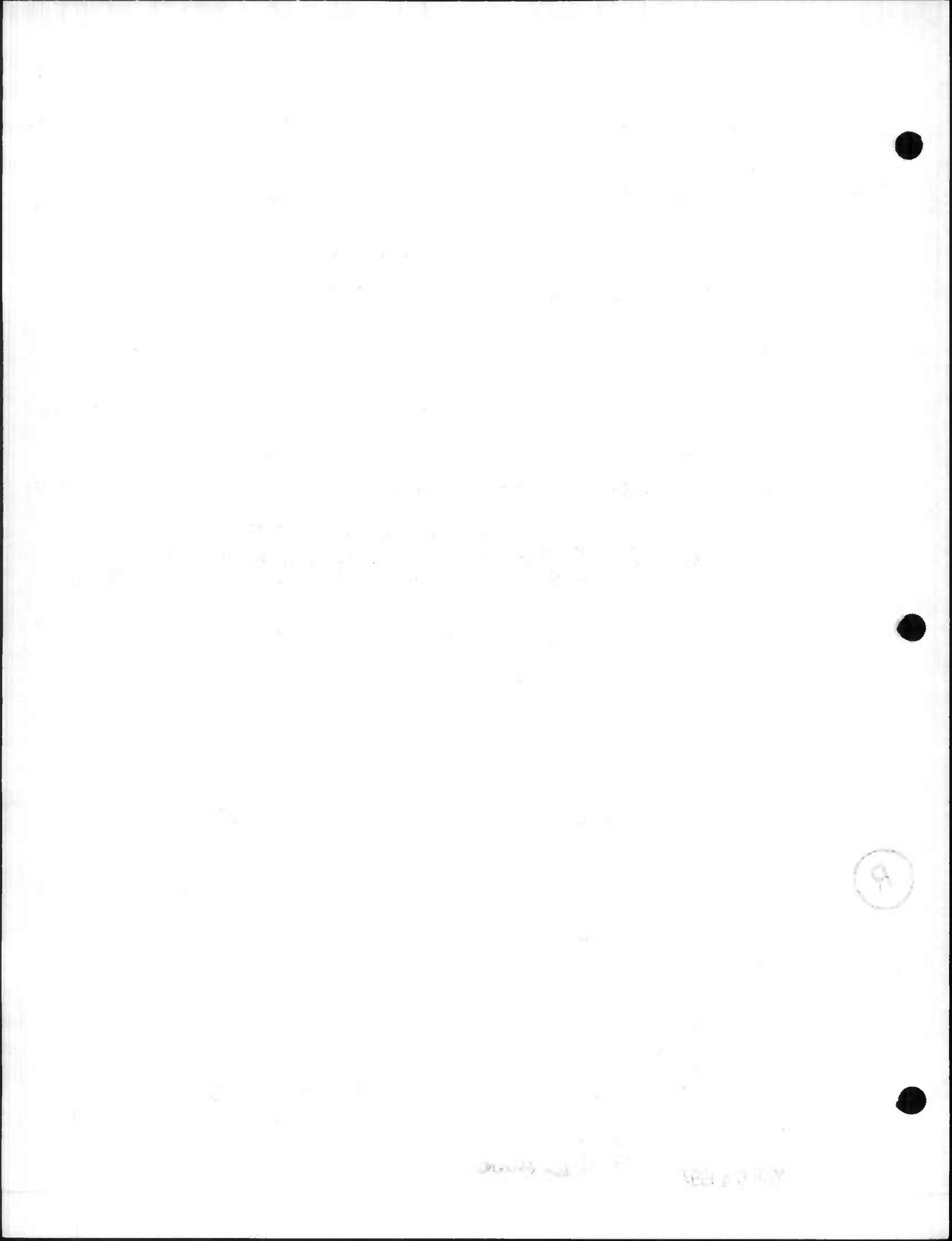
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: This certificate should be signed by the attending physician and to the Funeral Director: After this certificate is signed, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



97 06252

Reg. No.

DHMH 16 Rev 6/95

9

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06253

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN JOSEPH FURJANIC

2. Date of Death

Month Day Year  
FEBRUARY 27, 1997 9:03 a.m.

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

195-07-2471

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)  
8/11/10

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10a. State  
MD. BALTO. CO.

10b. County

10c. City, Town or Location  
TIMONIUM

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

316 E. TIMONIUM RD.

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give X  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
416a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

SALES MANAGER

16b. Kind of Business/Industry

EXXON

17. Father's Name (First, Middle, Last)

Mike Furjanic

18. Mother's Name (First, Middle, Maiden Surname)

Mary Gru Besic

19e. Informant's Name/Relationship (Type, Print)

Dorothy E. Furjanic

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

316 E. Timonium Rd., Timonium, MD 21093

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Holy Cross Cem -  
Harrisburg, PA

Data

4 MARCH  
1997

20c. Location - City or Town, State

Harrisburg, PA

21. Signature of Funeral Service Licensee

Victor Lengrand, Jr.  
Victor Lengrand, Jr.

22. Name and Address of Facility

Lemmon Funeral Home of Dulaney Valley, Inc.  
10 W. Padonia Rd., Timonium, MD 2109323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CARDIAC ARREST

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

28. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide28e. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?☐ Yes ☒ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how Injury occurred

29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

James E. Moulden, MD

29c. License number

D13629

29d. Date signed (Month, Day, Year)

2/27/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES E. MOULDEN, MD  
7505 OSKER DR. SUITES 508 TOWSON, MD 21204

31. Date filed (Month, Day, Year)

MAR 04 1997

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: This certificate must be signed by the attending physician and  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

2/1/88

290



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06254

|   |   |  |  |   |  |  |  |  |
|---|---|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CHARLES FRUSH SR.</b>                        |  |  |   | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>26</b> Year <b>97</b> |  | 3. Time of Death<br><b>0417</b>                          |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1420 SPRING AVENUE</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>ROSEDALE</b>                |  | 4c. County of Death<br><b>BALTIMORE</b>                  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-22-1065</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>9-12-27</b> | 9. Birthplace (State or Foreign Country)<br><b>MD</b>              |
|   | Usual Residence of Decedent   |  |  |   |  |  |  |  |
| 10a. State<br><b>MD</b>   |   | 10b. County<br><b>BALTIMORE</b>  |  | 10c. City, Town or Location<br><b>ROSEDALE</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 10e. Street and Number<br><b>1420 SPRING AVENUE</b>   |   |  |  | 10f. Zip Code<br><b>21237</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>   |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Superintendent</b>  |  | 16b. Kind of Business/Industry<br><b>Whiting Turner</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Harry Frush</b>   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mildred Cole</b>  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Dolores A. Frush /wife</b>   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1420 Spring Ave. Rosedale, MD 21237</b>   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oaklawn Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |  |  | 22. Name and Address of Facility<br><b>Cvach/Rosedale Funeral Home<br/>1211 Chesaco Ave. Baltimore, MD 21237</b>  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Self-inflicted gunshot wound of head</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |  |  |   |  |  |  | Approximate Interval Between Onset and Death                       |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic depression</b><br><b>Disseminated carcinoma (esophagus, liver)</b>   |   |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)<br><b>FEB 26, 1997</b>   |  | 28b. Time of Injury<br><b>0417 AM</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><b>Self-inflicted gunshot</b> |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   | 29b. Signature and title of certifier<br><b>J. Crossan Donovan, M.D.</b>   |  | 29c. License number<br><b>DO7632</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>FEB 26, 1997</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. CROSSAN DONOVAN M.D. 2112 DUNDALK AVE. BALTO MD. 21222</b>  |   |  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>   |   |  |  | 32. Registrar's Signature<br>   |  |  |  |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: Law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

9

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06255

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lugwig Galos

2. Date of Death

February 20, 1997

3. Time of Death

9:35AM

4a. Facility Name (If not institution, give street and number)

Prince George Community Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George

Funeral  
Director

5. Social Security Number

517-36-2238

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 18, 1913

9. Birthplace (State or Foreign Country)

Poland

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George

10c. City, Town or Location

New Carrollton

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

7212 Patterson Street

10f. Zip Code

20784

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

Damon Green, Sr., Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12810 Hallwood Place, Ft. Washington, MD 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

George Washington Cem. 2/24/97 Adelphi, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

D. N. Horton

22. Name and Address of Facility

R. N. Horton Co. Morticians, Inc.  
600 Kennedy Street, NW, DC 2001123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Laste. Seizures  
Due to (or as a consequence of):b. Bacteremia  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and DeathWKS  
day.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury of  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tara K. H. PGH, Chem? M.D. 20785

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show  
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/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06256

Item 6,12,17 per FH Film G745 3-4-97 rja

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |   |
|--|--|--|---|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ALVIN EUGENE GREENFELD</b>  |  |   | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>24</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>8:51 PM</b>   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SINAI HOSPITAL</b>  |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-18-2647</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.  | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days   | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 7, 1924</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>             |
|  | Usual Residence of Decedent  |  |   |  |  |  |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>  | 10b. County<br><b>BALTIMORE</b>  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
|  | 10e. Street and Number<br><b>11 SLADE AVENUE APT. 408</b>  |  |   | 10f. Zip Code<br><b>21208</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)  |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>BROKER</b>                         |  | 16b. Kind of Business/Industry<br><b>REAL ESTATE</b>   |  |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>LOUIS LOUIS GREENFELD</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SARAH SARAH FELDMAN</b>  |  |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>JUDITH D. GREENFELD / WIFE</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11 SLADE AVENUE APT. 408 BALTIMORE, MD 21208</b> |  |  |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BETH TFILOH</b>  |  | Date<br><b>2/27/97</b>   | 20c. Location - City or Town, State<br><b>BALTIMORE, MD</b>                                    |   |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 Reisterstown Road Pikesville, MD 21208</b>                            |  |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Ventricular fibrillation</b><br>Due to (or as a consequence of):<br>b. <b>Coronary artery disease</b><br>Due to (or as a consequence of):<br>c. <b>Myocardial infarction</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |   |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |  |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |  |  |   |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |   |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)                                      |   | 28b. Time of Injury<br><b>M</b>  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|  |  | 28d. Describe how injury occurred  |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |  |  |   |
| 29b. Signature and title of certifier<br>  |  |  | 29c. License number<br><b>A 30335</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 25, 1997</b>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>NILAN WILSON, MD 4000 Old Court Rd, Baltimore, MD 21208</b>   |  |  |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b><br>  |  |  |   |  |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The information on this certificate is to be used for the death certificate and is to be filed with the attending physician and the funeral director. After this certificate has been completed, it should be attached for use as the burial-transit completely filled in by the funeral director, page 2.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06257

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Flora Goodrich

2. Date of Death

Month  
Feb

Day

19

Year

97

3. Time of Death

4:55pm

4a. Facility Name (If not institution, give street and number)

Mariner Health of Laurel

4b. City, Town, or Location of Death

Laurel

4c. County of Death

P.G.

Funeral  
Director

5. Social Security Number

048-14-2798

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOV. 9, 1900

9. Birthplace (State or Foreign Country)

Connecticut

Usual Residence of Decedent

10a. State

Md.

10b. County

Prince Georges

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14200 Laurel Park Dr.

10f. Zip Code

20707

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

Collega (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Amos DuVois

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Germain

19a. Informant's Name/Relationship (Type, Print)

Thomas Goodrich son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

124 Lanchmont Terrace, Sebastian, Fl. 32958

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory, Inc.

Date

3/03/97

20c. Location - City or Town, State

Beltsville, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gary L. Kaufman Funeral Home at Meadowridge

7250 Washington Blvd., Elkridge, Md. 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Cerebrovascular Accident

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accidental6 ☐ Could not be determined3 ☐ Suicidal4 ☐ Homicidal

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

036716

29d. Date signed (Month, Day, Year)

2/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrew Kunkert M.D. 8317 Chesapeake Lane, Laurel MD 20707

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital Attending Physician: The law requires that the death certificate be executed within 48 hours of death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06258

Item 1 per PHY  
MEO Film G745 3-4-97 rja

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LILLIE

M.

GWYNN

2. Date of Death

Month Day Year

FEBRUARY 26, 1997

3. Time of Death

6:31PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL

Hospital Assn

Glen Burnie

ANNE ARUNDEL

5. Social Security Number

220-36-0106

6. Sex:

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

100

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 20, 1896

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12 Ferdinand Ave.

10f. Zip Code

21061

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Navar Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Billing Clerk

16b. Kind of Business/Industry

Retail Sales

17. Father's Name (First, Middle, Last)

Samuel Yates Beam

18. Mother's Name (First, Middle, Maiden Surname)

Martha Garber

19a. Informant's Name/Relationship (Type, Print)

Jean G. Webster / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12 Ferdinand Ave., Glen Burnie, Maryland 21061

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc.

Date

Feb. 28,

1997

20c. Location - City or Town, State

Catonsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Kirkley-Ruddick Funeral Home, P.A.

421 Crian Hwy., S.E., Glen Burnie, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerosis Heart Disease

many years

Due to (or as a consequence of):

b. Hypertension

many years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D38912

29d. Date signed (Month, Day, Year)

02-27-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1720 Crain Highway Suite 204 Glen Burnie MD 21061

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, play 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

(A)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06259

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY

E.

GABLE

2. Date of Death

Month

Day

Year

MARCH

02

1997

3. Time of Death

7:50 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

220-48-6447

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Month

Day

Year

November 15, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3949 Brooklyn Avenue

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Clarence Gruber

18. Mother's Name (First, Middle, Maiden Surname)

Edith Myers

19a. Informant's Name/Relationship (Type, Print)

Robert Gable ( Husband )

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3949 Brooklyn Avenue Balto., MD. 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Cedar Hill Cemetery

Date

3/6/97 Baltimore, Maryland

21. Signature of Funeral Service Licensee

Kevin E. Ecker

22. Name and Address of Facility

McCully Funeral Home of Brooklyn

237 E. Patapsco Ave. Balto., MD. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC COLON CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

&gt; 3 mos

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John A. Poolenz MD

29c. License number

D 47861

29d. Date signed (Month, Day, Year)

MARCH 02 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH BOATENS MD NORTH ARUNDEL HOSP., GLEN BURNIE MD 21061

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,


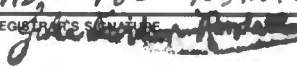
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and to the Funeral Director. If this certificate is not filed with the Registrar, page 2 should be detached for use as the burial-transit certificate.

9

97 06260

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GARY R GEISBERT</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>27</b> YEAR <b>97</b>  |  | 3. TIME OF DEATH<br><b>3 10 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-36-5817</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>56</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>3-14-40</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>ANNE ARUNDEL MEDICAL CENTER</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ANNAPOLIS</b>  |  |
| 9c. COUNTY OF DEATH<br><b>ANNE ARUNDEL</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Anne Arundel</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Pasadena</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>1585 Marco Drive</b>  |  |
| 10f. ZIP CODE<br><b>21122</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2 years</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Supervisor</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Dept. of Defense</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Frank R. Geisbert</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Virginia R. White</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Donna Geisbert</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1585 Marco Drive Pasadena, Maryland 21122</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Md. State Veteran Cem. 3/3</b>   |  | 20c. LOCATION — City or Town, State<br><b>Crownsville, Maryland</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>George J. Gonce Funeral Home P.A.<br/>4001 Ritchie Hwy. Baltimore, Md. 21225</b>  |  |  |  |
| 23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIOGENIC SHOCK</b><br>Approximate Interval Between Onset and Death <b>1 HOUR</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>CORONARY ARTERY DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>L.K. Essandoh</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D41417</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2-28-97</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>L.K. ESSANDOH, MD, 180 ADMIRAL COCHRANE DR, ANNAPOLIS MD</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 04 1997</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR AFTER DEATH: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: The law requires that the death certificate be completed and filed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Handwritten text at the bottom center, possibly a signature or date, which is mostly illegible due to fading.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06261

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Henry Scott Garrison

2. Date of Death

February 28, 1997

3. Time of Death

7:35 p.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Lorien Frankford Nursing Center

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

212-07-8834

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 7, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street end Number

2814 Erdman Avenue

10f. Zip Code

21213

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

18b. Kind of Business/Industry

Steel Production

17. Father's Name (First, Middle, Last)

William Garrison

18. Mother's Name (First, Middle, Maiden Surname)

(Not Known) Montgomery

19a. Informant's Name/Relationship (Type, Print)

Mark S. Garrison (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2814 Erdman Avenue Baltimore, Maryland 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem. 3/5/97

Date

20c. Location - City or Town, State

Baltimore Maryland

21. Signature of Funeral Service Licensee

Milton J Knight Jr

22. Name and Address of Facility

Leonard J. Ruck, Inc.

5305 Harford Rd. Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. recurrent aspiration pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 wks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Stroke

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. George Lowe

29c. License number

D20673

29d. Date signed (Month, Day, Year)

3/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. George Lowe, M.D. 5810 Belair Rd. Baltimore, Maryland

31. Date (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

George Lowe

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

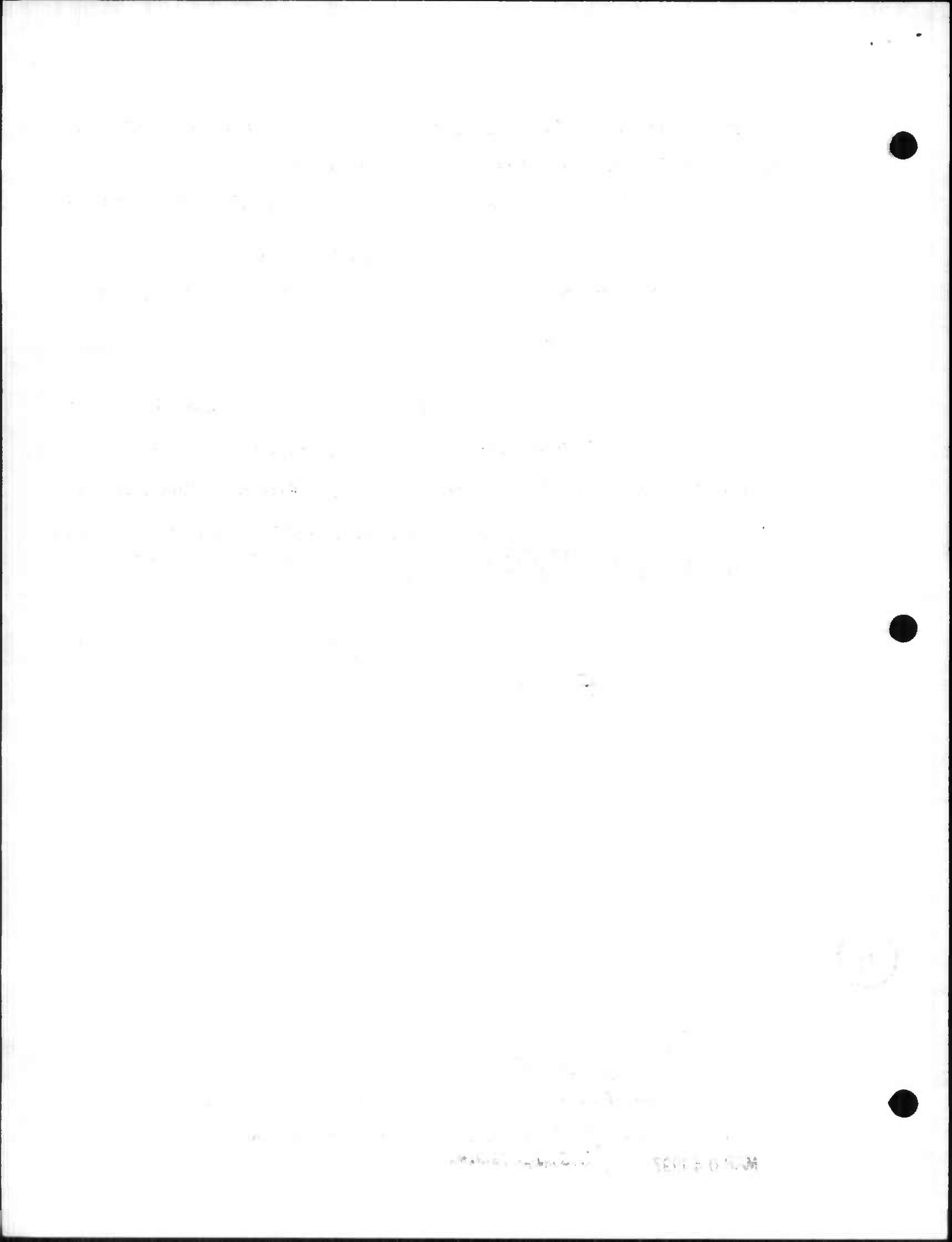
Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06262

## Certificate of Death

Reg. No.

|  |   |  |   |                                 |  |   |   |   |  |  |
|--|---|--|---|---------------------------------|--|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>STEPHEN GREGORY</b>  |  |   |                                 | 2. Date of Death<br>Month Day Year<br><b>February 26, 1997</b>   |   |   |   | 3. Time of Death<br><b>3:33PM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>STELLA MARIS AT MERCY HOSPITAL</b>   |  |   |                                 | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |   |   |   | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>236-46-2769</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |                                 | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>07/11/1931</b>        |   | 9. Birthplace (State or Foreign Country)<br><b>W. Virginia</b>                                 |  |
|  | Usual Residence of Decedent   |  |   |                                 |  |   |   |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>N/A</b>   |                                 | 10c. City, Town or Location<br><b>Baltimore</b>  |   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>2720 E. CHASE STREET</b>   |  |   |                                 | 10f. Zip Code<br><b>21213</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                  |   |  |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)  |  |   |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Orderly</b>  |   |   | 16b. Kind of Business/Industry<br><b>Hospital</b>                       |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Steven Gregory</b>  |  |   |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lula Wade</b>  |   |   |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Waymond Gregory</b>  |  |   |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2720 E. Chase Street, Baltimore, MD 21213</b>  |   |   |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arbutus Memorial Park 3/4</b>  |                                 | Data   |   | 20c. Location - City or Town, State<br><b>Arbutus, Maryland</b> |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Leroy O. Dyett</i>  |  |   |                                 | 22. Name and Address of Facility<br><b>LEREOY O. DYETT &amp; SON FUNERAL HOME, P.A.<br/>4600 LIBERTY HEIGHTS AVE., BALTO 21207</b>   |   |   |   |  |  |
|  | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):<br><b>b.</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Chronic Atrial Fibrillation</b><br><b>Chronic Renal Insufficiency</b><br><b>Heart</b> |  |   |                                 |  |   |   |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Atrial Fibrillation</b><br><b>Chronic Renal Insufficiency</b><br><b>Heart</b>  |  |   |                                 |  |   |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |   |                                 |  |   |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b> |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred                                       |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><i>Dr. J. J. J.</i>   |   |                                 |  |   |   |   |  |  |
| 29c. License number<br><b>D40480</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>February 27, 1997</b>  |   |                                 |  |   |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>FERNANDO J. FERRO, MD</b>   |   | 31. Data filed (Month, Day, Year)<br><b>MAR 04 1997</b>  |   |                                 |  |   |   |   |  |  |
| 32. Registrar's Signature<br><i>[Signature]</i>  |   | 33. Registrar's Name<br><b>BALTO., MD 21206</b>  |   |                                 |  |   |   |   |  |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar

DHMH 16 Rev 6/95



MAR 0 4 1935

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06263

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George Gordon

2. Date of Death

Month  
02Day  
17Year  
97

3. Time of Death

07:25 am

4a. Facility Name (If not institution, give street and number)

University Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

212-12-7650

6. Sex

XXM 2□F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jan 14, 1918

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1□ Yes 2□ No

10e. Street and Number

2420 W. Lanvale Street

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1□ Never Married 2□ Married  
3□ Widowed 4□ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1□ Yes 2□ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2□ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

Collage (1-4 or 5+)

12th Grade

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Sheet Metal Worker

16b. Kind of Business/Industry

U.S. Coast Guard

17. Father's Name (First, Middle, Last)

George Gordon

18. Mother's Name (First, Middle, Maiden Surname)

Bessie McFadden

19a. Informant's Name/Relationship (Type, Print)

Evelyn Gordon

wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2420 W. Lanvale Street Baltimore, Md. 21216

20a. Method of Disposition

1□ Burial 2□ Cremation 3□ Removal from State  
4□ Donation 5□ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Loudon Park

Date

Feb. 21

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

► *Samuel Poller*

22. Name and Address of Facility

Nutter Funeral Homes, Inc.

2501 Gwynns Falls PKWY Baltimore, Md. 21216

Physician  
/Medical  
Examiner23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ruptured aortic aneurysm

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

8 hours

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Intracerebral hematoma

Due to (or as a consequence of):

3 days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2□ No 3□ Probably 4□ Unknown

24a. Was an autopsy  
performed?

1□ Yes 2□ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1□ Yes 2□ No

25. Was case referred to medical  
examiner?

1□ Yes 2□ No

Hospital:

1□ Inpatient

2□ ER/Outpatient

3□ DOA

Other:

26. Place of Death (Check only one)

4□ Nursing Home 5□ Residence 6□ Other (Specify)

27. Manner of Death

1□ Natural 5□ Pending  
2□ Accident investigation  
3□ Suicide 6□ Could not be  
4□ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?

1□ Yes 2□ No

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1□ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

► *Mark E. Lewis*

29c. License number

D10036

29d. Date signed (Month, Day, Year)

2/17/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barbara E. Lazio  
22 S. Greene St., Baltimore MD 21201

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

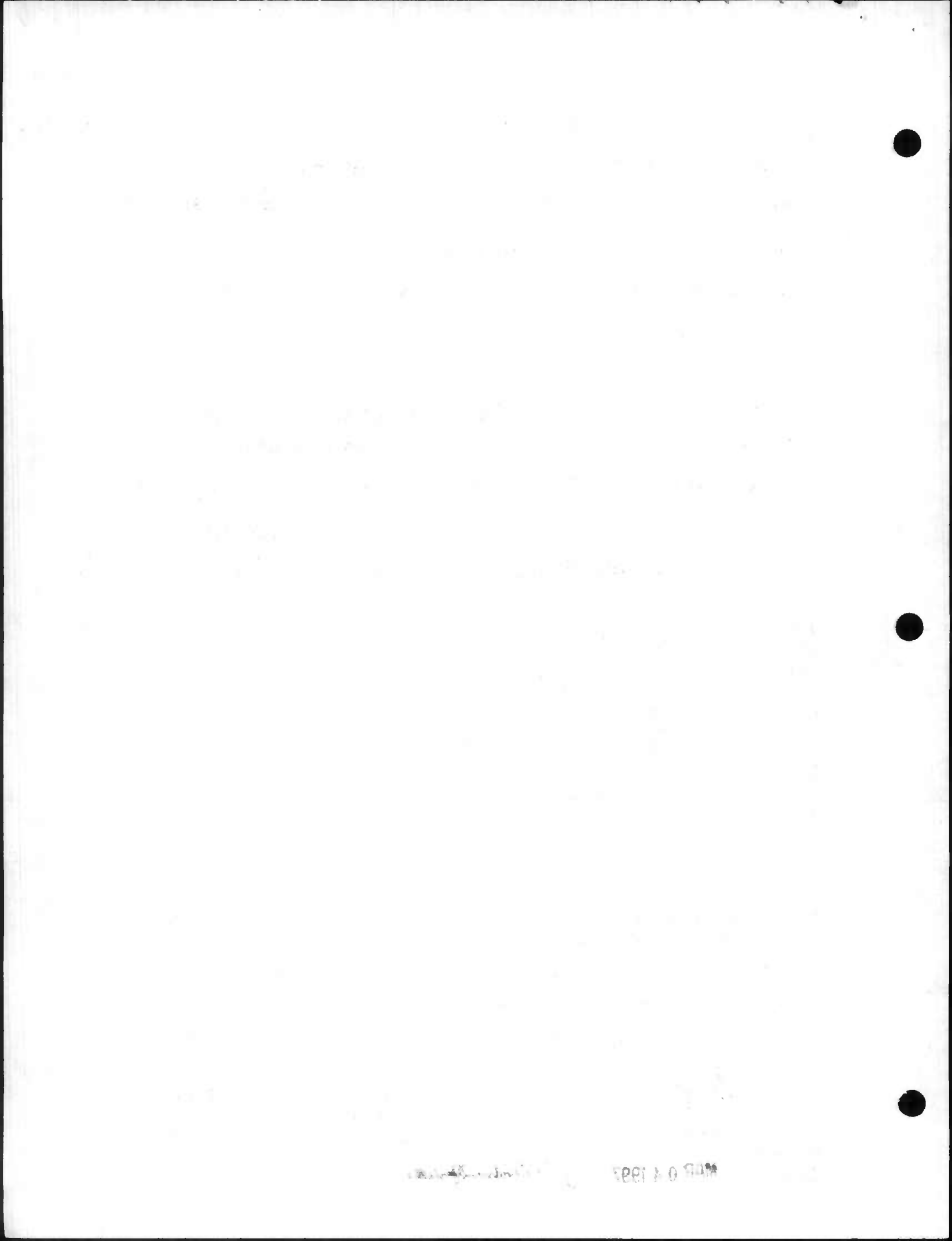
► *Frederick R. Riddell*State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06264

Reg. No.

|  |  |                             |   |   |   |   |  |  |
|--|--|-----------------------------|---|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>Charles William Gray   |                             |   |   | 2. Date of Death<br>Month Day Year<br>March 2 1997  |   | 3. Time of Death<br>10:00 AM   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>3631 Fontron Drive   |                             |   |   | 4b. City, Town, or Location of Death<br>Edgewater   |   | 4c. County of Death<br>Anne Arundel  |  |
| Funeral<br>Director  | 5. Social Security Number<br>578 10 9973   |                             | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>77 Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                          | 8. Date of Birth (Month, Day, Year)<br>Nov 19 1919   | 9. Birthplace (State or Foreign Country)<br>VA |
|  | Usual Residence of Decedent  |                             |   |   |   |   |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br>MD   | 10b. County<br>Anne Arundel |   | 10c. City, Town or Location<br>Edgewater  |   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br>3631 Fontron Drive   |                             |   | 10f. Zip Code<br>21037                    |   | 10g. Citizen of What Country?<br>USA                    |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |                             | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1944-46   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collage (1-4 or 5+)<br>8th  |                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Maintenance Engineer   |   |   | 16b. Kind of Business/Industry<br>Bakery                |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>William T. Gray   |                             |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Virginia Leslie Legg   |   |  |  |
| To Be Completed by Physician/Medical Examiner                        | 19a. Informant's Name/Relationship (Type, Print)<br>Rebecca Lee/daughter   |                             |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3635 Fontron Dr., Edgewater, Md 21037  |   |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Lakemont Cemetery   |   | Data<br>3/05 1997   | 20c. Location - City or Town, State<br>Davidsonville Md |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |                             |   |   | 22. Name and Address of Facility<br>Hardesty Funeral Home PA<br>12 Ridgely Ave., Annapolis, Md 21401  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Severe Chronic Congestive Heart failure 1+ year<br>Due to (or as a consequence of):<br>b. Dilated Cardiomyopathy 5+ years<br>Due to (or as a consequence of):<br>c. Atherosclerotic Coronary Artery Disease 25+ years<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                             |   |   |   |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Chronic Obstructive Pulmonary Disease<br>Peripheral Vascular Disease<br>Chronic Renal Failure  |                             |   |   |   |   |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                             | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |   |   |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |                             | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  |
|  |  |                             | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred   |   |  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |                             | 29b. Signature and title of certifier<br><i>[Signature]</i>   |   | 29c. License number<br>D11653   |   | 29d. Date signed (Month, Day, Year)<br>March 3, 1997   |  |
|  | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br>Peter F. VERKOUW MD - 2003 Forest Drive, Annapolis MD, 21401   |                             |   |   |   |   |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br>MAR 04 1997   |                             |   |   | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital for Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

JA



RECEIVED

SEP 11 1974

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06265

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |  |  |                                      |  |
|---|---|--|---|--|---|--|--|--------------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>MARIE HELEN GOLD                      |  |   |  | 2. Date of Death<br>Month Day Year<br>MARCH 2, 1997 |  | 3. Time of Death<br>6:27am                           |                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>1004 Omar Drive |  |   |  | 4b. City, Town, or Location of Death<br>Crownsville |  | 4c. County of Death<br>Anne Arundel                  |                                      |  |
| Funeral<br>Director   | 5. Social Security Number<br>469-18-7288  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>77 Yrs.           |  | 8. Date of Birth (Month, Day, Year)<br>Oct. 30, 1919 |                                      |  |
|   | 9. Birthplace (State or Foreign Country)<br>Minnesota                             |  | 10a. State<br>MD  |  | 10b. County<br>Anne Arundel                         |  | 10c. City, Town or Location<br>Crownsville           |                                      |  |
| Usual Residence of Decedent   |   |  |   |  |   |  |  |                                      |  |
| 10a. State<br>MD  |   |  | 10b. County<br>Anne Arundel   |  |   | 10c. City, Town or Location<br>Crownsville   |  |                                      |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  | 10e. Street and Number<br>1004 Omar Drive   |  |   | 10f. Zip Code<br>21032   |  | 10g. Citizen of What Country?<br>USA |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |                                      |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: White  |   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 Collegia (1-4 or 5+) 4                              |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Bookkeeper  |  |                                      |  |
| 16b. Kind of Business/Industry<br>Lumber Industry   |   |  | 17. Father's Name (First, Middle, Last)<br>Charles Thompson   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elizabeth Zollman   |  |                                      |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Harry M. Gold   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1004 Omar Drive, Crownsville, MD 21032               |  |   |  |  |                                      |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory   |  |   | 20c. Location - City or Town, State<br>3/3/97 Baltimore, MD  |  | 20d. Date                            |  |
| 21. Signature of Funeral Service Licensee<br>   |   |  | 22. Name and Address of Facility<br>HARDESTY FUNERAL HOME P.A.<br>851 ANNAPOLIS RD. GAMBRILLS MD 21054  |  |   |  |  |                                      |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Breast cancer  |   |  |   |  |   |  |  |                                      |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   |  |   |  |  |                                      |  |
| 23c. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |  |   |  |   |  |  |                                      |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  |   |  |  |                                      |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |  |   |  |  |                                      |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  |   |  |  |                                      |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |   |  |   |  |   |  |  |                                      |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   |  |   |  |   |  |  |                                      |  |
| 28a. Date of Injury (Month, Day, Year)  |   |  |   |  |   |  |  |                                      |  |
| 28b. Time of Injury<br>M  |   |  |   |  |   |  |  |                                      |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |  |   |  |  |                                      |  |
| 28d. Describe how injury occurred   |   |  |   |  |   |  |  |                                      |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   |  |   |  |  |                                      |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |   |  |  |                                      |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |   |  |  |                                      |  |
| 29b. Signature and title of certifier<br>  |   |  |   |  |   |  |  |                                      |  |
| 29c. License number<br>019838   |   |  |   |  |   |  |  |                                      |  |
| 29d. Date signed (Month, Day, Year)<br>3/3/97   |   |  |   |  |   |  |  |                                      |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Stuart E. Selouch, M.D. 900 Beattgate Rd. Annapolis, Md.  |   |  |   |  |   |  |  |                                      |  |
| 31. Date filed (Month, Day, Year)<br>MAR 04 1997  |   |  |   |  |   |  |  |                                      |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

AL

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06266

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EARL M. HENRY

2. Date of Death

MARCH 3, 1997

3. Time of Death

6:40 PM

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL ASSN GLEN BURNIE

4b. City, Town, or Location of Death

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

219-10-6523

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 1 1926

9. Birthplace (State or Foreign Country)

Balto. Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

980 Pebblestone Rd.

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

Trueland Electric Contractors

17. Father's Name (First, Middle, Last)

Elmer B. Henry, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Anna Louise Hettche

19a. Informant's Name/Relationship (Type, Print)

Thomas W. Henry/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1805 Hanford Road Baltimore, Md. 21237

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Mem. Park

Date

MARCH 7 1997

20c. Location - City or Town, State

Easton, Md.

21. Signature of Funeral Service Licensee

Daniel A. Taylor

22. Name and Address of Facility

McCully Funeral Home of Brooklyn  
237 E. Patapsco Ave. Baltimore, Md. 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. ASPINATION PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. CHRONIC OBSTRUCTIVE LUNG DISEASE

Due to (or as a consequence of):

5 YEARS

c. RHABDOMYOLYSIS

Due to (or as a consequence of):

3 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CEREBROVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dan H. Schreiber MD

29c. License number

028221

29d. Date signed (Month, Day, Year)

MARCH 4, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAN H. SCHREIBER MD 301 HOSPITAL DRIVE GLEN BURNIE MARYLAND

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

[Signature]

21061

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

1991, 1992)

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State of Maryland / Department of Health and Mental Hygiene

97 06267

## Certificate of Death

Reg. No.

|  |  |  |   |  |   |  |   |  |  |  |                                      |  |  |  |
|--|--|--|---|--|---|--|---|--|--|--|--------------------------------------|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Andrew Hinz</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>February 28 1997</b>   |  | 3. Time of Death<br><b>11:45am</b>  |  |  |  |                                      |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Greater Baltimore Medical Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Towson</b>   |  | 4c. County of Death<br><b>Baltimore</b>   |  |  |  |                                      |  |  |  |
| Funeral<br>Director  | 5. Social Security Number  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.               | 8. Date of Birth<br>(Month, Day, Year)<br><b>2/28/97</b>  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |  |                                      |  |  |  |
|  | Usual Residence of Decedent  |  |   |  |   |  |   |  |  |  |                                      |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Pikesville</b>  |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |                                      |  |  |  |
|  | 10e. Street and Number<br><b>4 Estates Court</b>   |  |   |  | 10f. Zip Code<br><b>21208</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>   |  |  |  |                                      |  |  |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |  |  |                                      |  |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>N/A</b>  |  |   | 16b. Kind of Business/Industry<br><b>N/A</b> |   |  |  |  |                                      |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Brad John Hinz</b>   |  |   |  | 16. Mother's Name (First, Middle, Maiden Surname)<br><b>Laurel Heaps</b>  |  |   |  |  |  |                                      |  |  |  |
| To Be Completed by Physician/Medical Examiner                                | 19a. Informant's Name/Relationship (Type, Print)<br><b>Greater Baltimore Medical Center</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6701 North Charles Street Baltimore MD 21204</b>  |  |   |  |  |  |                                      |  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GREEN MOUNT CREMATORY</b>  |  | 20c. Location - City or Town, State<br><b>3-4-97 BALTO., MD., 21202</b>   |  |   |  |  |  |                                      |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>HENRY W. JENKINS AND SONS COMPANY<br/>4905 YORK ROAD, BALTIMORE, MARYLAND, 21212</b>   |  |   |  |  |  |                                      |  |  |  |
|  | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Immaturity due to prematurity</b><br><br>Due to (or as a consequence of):<br><b>Premature rupture of membranes</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>{</b><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br><b>1/2 hour</b>  |  |  |                                      |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |                                      |  |  |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020 | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |  |                                      |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |                                      |  |  |  |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |                                      |  |  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |  |   |  | 29b. Signature and title of certifier<br> |  | 29c. License number<br><b>D36226</b> |  | 29d. Date signed (Month, Day, Year)<br><b>3/2/97</b> |  |
|  | 30. Name and address of person who completed cause of death (Item 29a) (Type, Print)<br><b>Rebecca A. Ludwig, M.D. GBMC 6701 North Charles Street Baltimore MD 21204</b>   |  |   |  |   |  |   |  |  |  |                                      |  |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>  |  |   |  | 32. Registrar's Signature<br>  |  |   |  |  |  |                                      |  |  |  |

9

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06268

## Certificate of Death

Reg. No.

|   |  |   |   |  |  |   |  |   |
|---|--|---|---|--|--|---|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>BELLA HARRISON</b>  |   |   |  | 2. Date of Death<br>Month <b>FEB</b> Day <b>28</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>9.45 AM</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>LEVINDALE</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |   | 4c. County of Death<br><b>N/A</b>  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>578-18-2204</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.  | If Under 1 Year<br>Months Days                           | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>JULY 16, 1920</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>WASHINGTON, DC</b> |
|   | Usual Residence of Decedent  |   |   |  |  |   |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>  | 10b. County<br><b>BALTIMORE</b>   |   | 10c. City, Town or Location<br><b>BALTIMORE</b>          |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
|   | 10e. Street and Number<br><b>6908 MARSUE DR., APT. T-2</b>   |   |   | 10f. Zip Code<br><b>21215</b>                            |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |   |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>NONE</b>                          |  | 16b. Kind of Business/Industry<br><b>NONE</b>  |   |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>MEYER HARRISON</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>YEDDA SCHRIBEMAN</b>   |   |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>DAVID HARRISON (NEPHEW)</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8225 TOWNSHIP DR. OWINGS MILLS, MD 21117</b>   |   |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>KING DAVID MEM. GARDEN</b>   |  | Date<br><b>3/2/97</b>  |   | 20c. Location - City or Town, State<br><b>FALLS CHURCH, VA</b>   |   |
|   | 21. Signature of Funeral Service Licensee<br><i>Scott M. Cottle</i>  |   |   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN RD., PIKESVILLE, MD 21208</b>  |   |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ASPIRATION PNEUMONIA</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |  |  |   |  |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |
|   |  |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                   |  |   |
|   |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>                          |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |
|   |  | 28d. Describe how injury occurred   |   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |
|   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |  |   |  |   |
| 29b. Signature and title of certifier<br><i>SEYER</i> <b>ATTENDING PHYSICIAN</b>  |  |   |   | 29c. License number<br><b>D25610</b>                     |  | 29d. Date signed (Month, Day, Year)<br><b>FEB. 28. 1997</b>   |  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>LEVINDALE 2434 WEST BELVERDERE AVENUE BALTIMORE MD 21215</b>   |  |   |   |  |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>   |  |   |   | 32. Registrar's Signature<br><i>Julie Duplan-Randall</i> |  |   |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06269

Items: 23 part I, 27 per MEO G-745 3/11/97 reb

Certificate of Death

Reg. No.

|  |   |  |   |  |  |   |   |  |
|--|---|--|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JOSEPH ALLAN HERSHMAN</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>February 23, 1997</b>   |   | 3. Time of Death<br><b>4:55p</b>  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>FRANKLIN SQUARE HOSPITAL</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>ESSEX</b>   |   | 4c. County of Death<br><b>BALTIMORE</b>                                 |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-64-1351</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>43</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 18, 1954</b>             |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Baltimore, Md.</b>   |  |   |  |  |   |   |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |  |   |  |  |   |   |  |
|  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|  | 10e. Street and Number<br><b>4112 Cliffvale Road</b>  |  |   |  | 10f. Zip Code<br><b>21236</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th.</b> College (1-4 or 5+) <b>n/a</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Custodian/Elmwood Elem.Sch.</b>  |   | 16b. Kind of Business/Industry<br><b>Baltimore Co.Sch.System</b>        |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Dailey Earle Hershman</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Charlene S. Hebb</b>   |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Elizabeth N. Hershman (Wife)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4112 Cliffvale Road Baltimore, Md. 21236</b>   |   |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Churchville Presby.Ch.Cem.</b>                                       |  | 20c. Date<br><b>Feb. 27, 1997</b>  |   | 20d. Location - City or Town, State<br><b>Churchville, Md.</b>          |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>E. F. Lassahn Funeral Home<br/>11750 Belair Road Kingsville, Md. 21087</b>  |   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                             |  |   |  |  |   |   |  |
| Physician<br>/Medical<br>Examiner  | Immediate Cause (Final disease or condition resulting in death)<br><b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>   |  |   |  |  |   |   |  |
|  | Due to (or as a consequence of):  |  |   |  |  |   |   |  |
|  | Due to (or as a consequence of):  |  |   |  |  |   |   |  |
|  | Due to (or as a consequence of):  |  |   |  |  |   |   |  |
|  | Due to (or as a consequence of):  |  |   |  |  |   |   |  |
|  | Due to (or as a consequence of):  |  |   |  |  |   |   |  |
|  | Due to (or as a consequence of):  |  |   |  |  |   |   |  |
|  | Due to (or as a consequence of):  |  |   |  |  |   |   |  |
|  | Due to (or as a consequence of):  |  |   |  |  |   |   |  |
|  | Due to (or as a consequence of):  |  |   |  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   |  |  |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |  |   |  |  |   |   |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred  |   |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |  |   |   |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |  |  |   |   |  |
| 29b. Signature and title of certifier<br>  |   |  |   | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>February 24, 1997</b>                             |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. LARON Locke, MD 111 Penn Street, Baltimore, Maryland 21201</b>   |   |  |   |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>  |   |  |   | 32. Registrar's Signature<br>  |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: The law requires that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06270

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHRISTINE HACKETT

2. Date of Death

Month  
FEBRUARY 24, 1997

3. Time of Death

8:40 P

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Baltimore City

Funeral  
Director

5. Social Security Number

232-5B-7037

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

5B

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year  
May 16, 1938

9. Birthplace (State or Foreign Country)

Fairmont, W.VA.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

BelAir

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2409 West Medical Hall Road

10f. Zip Code

21015

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th.College (1-4 or 5+)  
6yrs.16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Physical Education Teacher

16b. Kind of Business/Industry

Harford Co. Public Sch. Sys.

17. Father's Name (First, Middle, Last)

Paul E. Davis

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Frame

19a. Informant's Name/Relationship (Type, Print)

John Stephen Scott, Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

103 Bourbon Court Baltimore, Md. 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harford Memorial Gardens Mar. 1, 1997

Date

20c. Location - City or Town, State

Aberdeen, Maryland

21. Signature of Funeral Service Licensee

E. F. Lassahn

22. Name and Address of Facility

E. F. Lassahn Funeral Home

11750 Belair Road Kingsville, Md. 21087

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CHRONIC MYELOMONOCLYTIC LEUKEMIA BLAST CRISIS

1 MONTH

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residencia6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier

E. F. Lassahn MD

29c. License number

D47390

29d. Date signed (Month, Day, Year)

2/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IVAN BORIELLO MD JOHNS HOPKINS ONCOLOGY CENTER 600 N. WOLFE ST. BALTIMORE MD

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

J. P. Warden

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours of death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06271

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rudolf M. Hooper

2. Date of Death  
Month Day Year

02 - 27 - 97

3. Time of Death

12:06 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Med Center ER

4b. City, Town, or Location of Death

Baltimore, Md

4c. County of Death

N/A

5. Social Security Number

152-16-1242

6. Sex  
☒ M ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

MAY 13 1927

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4111 N. PORT STREET 2nd Flr.

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8th grade

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

SECURITY OFFICER

16b. Kind of Business/Industry

SECURITY

17. Father's Name (First, Middle, Last)

WILLIAM FISHER

18. Mother's Name (First, Middle, Maiden Surname)

GLADYS HOOPER

19e. Informant's Name/Relationship (Type, Print)

Geraldine Jones/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4111 N. Port Street 2nd Flr, Baltimore, Maryland 21224

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST VETERANS

Date

3-6-97

20c. Location - City or Town, State

OWINGS MILLS, MARYLAND

21. Signature of Funeral Service Licensee

Harris O. Owe

22. Name and Address of Facility

WILLIAM C. BROWN COMMUNITY F/H  
1206 W. NORTH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac arrest, Congestive heart failure minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic Renal Failure years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital

☐ Inpatient☒ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural  
☐ Accident  
☐ Suicide  
☐ Homicide☐ Pending Investigation  
☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. B. Zachary, M.D.

29c. License number

D12052

29d. Date signed (Month, Day, Year)

Feb 27, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Johns Hopkins Bayview Med Center, Baltimore, Md. 21224

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

J. B. Zachary

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The cause of death at the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06272

## Certificate of Death

Reg. No.

|  |  |  |  |   |  |  |  |  |
|--|--|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>HATTIE HUGHES</b>                           |  |  |   | 2. Date of Death<br>Month Day Year<br><b>03 01 97</b>    |  | 3. Time of Death<br><b>0656</b>                            |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>ST AGNES HOSPITAL</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b> |  | 4c. County of Death<br><b>N/A</b>                          |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>240-62-1375</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>59</b> Yrs.         |  | 8. Date of Birth (Month, Day, Year)<br><b>AUG. 4, 1937</b> |  |
|  | Usual Residence of Decedent  |  | 10a. State<br><b>MD.</b>   |   | 10b. County<br><b>N/A</b>                                |  | 10c. City, Town or Location<br><b>BALTIMORE</b>            |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>332 S. Franklan Town Rd.</b>  |  | 10f. Zip Code<br><b>21223</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11TH</b> Collage (1-4 or 5+) <b></b>   |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired.)<br><b>NURSING ASSISTANT</b>   |  | 18b. Kind of Business/Industry<br><b>HOSPITAL</b>   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>ROBERT SIMMONS</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>HATTIE PHILLIPS</b>  |  | 19e. Informant's Name/Relationship (Type, Print)<br><b>JAMES E. HUGHES</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>332 S. Franklan Town Rd, Balt, MD, 21223</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>WOODLAWN</b>  |  | 20c. Location (City or Town, State)<br><b>3/6/97 Woodlawn MD,</b>   |  | 20d. Location (City or Town, State)<br><b>270 FREDERICK PASS BALT, MD, 21229</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br><b>GARY P. MARCHE FUNERAL HOME P.A</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Acute Myocardial Infarction</b><br>Due to (or as a consequence of):<br><b>Arteriosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><b>Hypertension</b><br>Due to (or as a consequence of):<br><b></b> |  | Approximate Interval Between Onset and Death<br><b>1 hour</b><br><b>10 years</b><br><b>10 years</b>  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b></b>  |  |  |
| 28b. Time of Injury<br><b></b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><b></b>  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b></b>  |  |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>[Signature]</i>  |  | 29c. License number<br><b>D38543</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 1, 1997</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>KEVIN H. SCRUGGS MD 900 CATON AVENUE BALTIMORE, MARYLAND 21229</b>  |  | 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

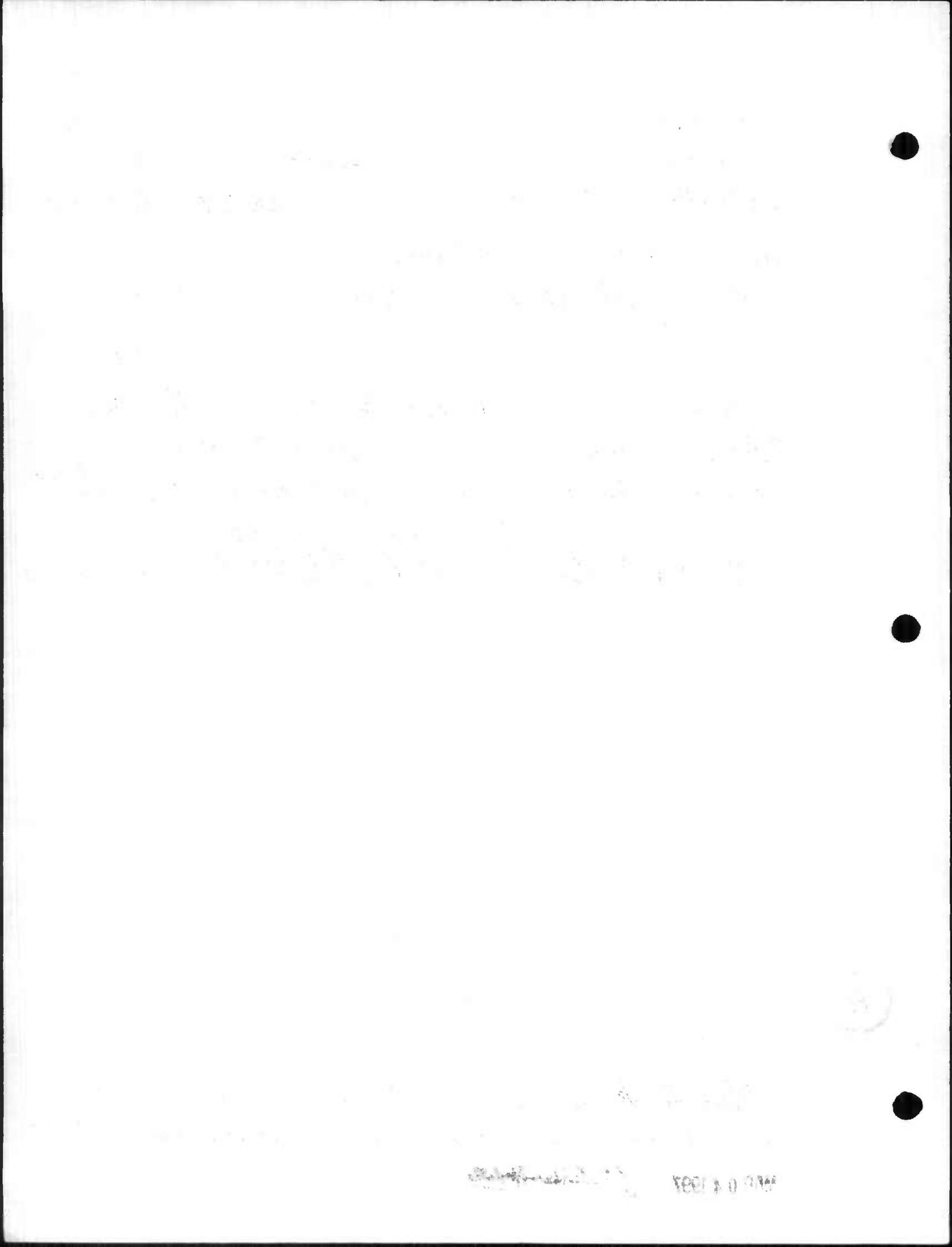
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours of death.

To the Funeral Home: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06273

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rosella Leota Hanning

2. Date of Death

Month Day Year  
March 2, 1997

3. Time of Death

9:30 PM

4a. Facility Name (If not institution, give street and number)

26024 Mt. Vernon Ave.

4b. City, Town, or Location of Death

Damascus

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

225-40-0361

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 29, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Damascus

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

26024 Mt. Vernon Avenue

10f. Zip Code

20872

10g. Citizen of What Country?

American

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Draftsman

16b. Kind of Business/Industry

Vitro Engineering

17. Father's Name (First, Middle, Last)

William Wilson Folk

18. Mother's Name (First, Middle, Maiden Surname)

Arminta Mae Otto

19a. Informant's Name/Relationship (Type, Print)

Audrienne Mae Runkles - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

26024 Mt. Vernon Avenue, Damascus, Maryland 20872

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Springs Upper Cemetery

Date

3/6/97

20c. Location - City or Town, State

Springs, Pennsylvania

21. Signature of Funeral Service Licensee

Olin L. Molesworth

22. Name and Address of Facility

Olin L. Molesworth, P.A., Funeral Home

26401 Ridge Road, Damascus, Maryland 20872

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. HYPERTENSIVE COR PULMONALE

Due to (or as a consequence of):

ASTHMA

Approximate  
Interval Between  
Onset and Death

1 YEAR

b. Due to (or as a consequence of):

50 YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Frank J. Mayo, M.D.

29c. License number

D23630

29d. Date signed (Month, Day, Year)

March 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frank J. Mayo, M.D., 16220 Frederick Rd., Suite 213, Gaithersburg, Md. 20877

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

Frank J. Mayo

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

6. 5



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 06274

Reg. No.

|   |  |  |   |   |  |  |  |   |
|---|--|--|---|---|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Benedict Kavanaugh Hutson                    |  |   |   | 2. Date of Death<br>Month Day Year<br>February 28 1997 |  | 3. Time of Death<br>8:20 PM  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br>6620 Walnutwood Circle |  |   |   | 4b. City, Town, or Location of Death<br>Rodgers Forge  |  | 4c. County of Death<br>Baltimore   |   |
| Funeral<br>Director   | 5. Social Security Number<br>219-18-0894   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>73 Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                         | 8. Date of Birth<br>(Month, Day, Year)<br>April 15, 1923   | 9. Birthplace (State or Foreign Country)<br>Maryland   |   |
|   | Usual Residence of Decedent  |  |   |   |  |  |  |   |
| 10a. State<br>Maryland  |  | 10b. County<br>Baltimore   |   | 10c. City, Town or Location<br>Rodgers Forge  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br>6620 Walnutwood Circle  |  |  |   | 10f. Zip Code<br>21212  |  | 10g. Citizen of What Country?<br>United States   |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WWII   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4  |  |  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Company President   |  | 16b. Kind of Business/Industry<br>Rending  |  |   |
| 17. Father's Name (First, Middle, Last)<br>William Howard Hutson  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elizabeth Anna Kavanaugh   |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Helen Hutson/wife   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6620 Walnutwood Circle Baltimore, MD 21212   |  |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Parkwood Cemetery  |   | Date<br>3/3/97  |  | 20c. Location - City or Town, State<br>Baltimore, Maryland   |  |   |
| 21. Signature of Funeral Service Licensee<br>John O. Mitchell IV  |  |  |   | 22. Name and Address of Facility<br>Mitchell-Wiedefeld Home, Inc.<br>6500 York Rd.<br>Baltimore, Md 21212   |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. LIVER METASTASES<br>Due to (or as a consequence of):<br>b. PANCREATIC CANCER<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |   |   |  |  |  | Approximate Interval Between Onset and Death<br>unknown<br>5 mos  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|   |  |  |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |   |   |  |  |  |   |
| 29b. Signature and title of certifier<br>Kendall P. Boullens  |  | 29c. License number<br>D25643  |   | 29d. Date signed (Month, Day, Year)<br>3/3/97   |  |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>K P Faulkner / 2300 Swaney Valley Rd / Balto MD 21204   |  |  |   |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br>MAR 04 1997  |  | 32. Registrar's Signature<br>Julia [Signature]   |   |   |  |  |  |   |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06275

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

NAOMI L. HARRIS

2. Date of Death

Month

Day

Year

2 28 97

3. Time of Death

11:03 AM

4a. Facility Name (If not institution, give street and number)

LORIAN FRANKFORD N.H.

4b. City, Town, or Location of Death

BARTO.

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

218-09-7996

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month Day Year)

5/11/19

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3807 Pinewood Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Assembly Line Worker

16b. Kind of Business/Industry

Electronics Plant

17. Father's Name (First, Middle, Last)

George James Smith

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Augusta Koch

19a. Informant's Name/Relationship (Type, Print)

Harriet Frances Dean/ Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3807 Pinewood Avenue, Baltimore, Maryland 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cemetery 3/3/97

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

John C. Miller, Inc.  
6415 Belair Road Baltimore, Maryland 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. END STAGE CHRONIC OBSTRUCTIVE PULMONARY DZ. 46 YRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

(R) ML lesion on CxR

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Signature and title of certifier

[Signature], MD.

29e. License number

D41291

29f. Date signed (Month, Day, Year)

2/28/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JONATHAN GITTER MD. 21 CROSSROADS DR. #330 OWINGS MILLS 21117

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Initials

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1991-0-0000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06276

## Certificate of Death

Reg. No.

|  |   |   |   |   |  |   |  |                                   |  |
|--|---|---|---|---|--|---|--|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><u>Perry Johnson</u>                        |   |   |   | 2. Date of Death<br>Month <u>February</u> Day <u>26</u> Year <u>1997</u> |   | 3. Time of Death<br><u>3:05 PM</u>   |                                   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>Sinai Hospital</u> |   |   |   | 4b. City, Town, or Location of Death<br><u>Baltimore</u>                 |   | 4c. County of Death<br><u>N/A</u>  |                                   |  |
| Funeral<br>Director  | 5. Social Security Number<br><u>217-26-1088</u>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                | 7. Age (In yrs. last birthday)<br><u>65</u> Yrs.  | If Under 1 Year<br>Months <u>    </u> Days <u>    </u>                   | If Under 24 Hrs.<br>Hours <u>    </u> Min. <u>    </u>                                      | 8. Date of Birth (Month, Day, Year)<br><u>March 8, 1931</u>                                    |                                   |  |
|  | 9. Birthplace (State or Foreign Country)<br><u>Va.</u>                                  |   |   |   |  |   |  |                                   |  |
| Usual Residence of Decedent  |   |   |   |   |  |   |  |                                   |  |
| 10a. State<br><u>Md.</u>   |   | 10b. County<br><u>N/A</u>   |   | 10c. City, Town or Location<br><u>Baltimore</u>   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                   |  |
| 10e. Street and Number<br><u>2460 Shirley Avenue</u>   |   |   |   | 10f. Zip Code<br><u>21215</u>   |  | 10g. Citizen of What Country?<br><u>U.S.A.</u>  |  |                                   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <u>5/1951</u><br>If Yes, Give Year or Dates: <u>6/1951</u> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <u>    </u>  |  | 14. Race - American Indian, Black, White, etc.<br>Specify <u>Black</u>                      |  |                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12th Grade</u> College (1-4or 5+)  |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Supervisor</u>  |  | 16b. Kind of Business/Industry<br><u>Baltimore Gas &amp; Electric</u>                       |  |                                   |  |
| 17. Father's Name (First, Middle, Last)<br><u>Thomas Johnson</u>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Percy Lovejoy</u>   |  |   |  |                                   |  |
| 19a. Informant's Name/Relationship (Type, Print) <u>daughter</u><br><u>Renee Sanders</u>   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>2460 Shirley Avenue Baltimore, Md. 21215</u>  |  |   |  |                                   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u>    </u>  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Garrison Forest Veterans</u> |   | Data<br><u>March 4</u>   |   | 20c. Location - City or Town, State<br><u>Wings Mills, Md.</u>                                 |                                   |  |
| 21. Signature of Funeral Service Licensee<br><u>H. E. Nutter</u>   |   |   |   | 22. Name and Address of Facility<br><u>Nutter Funeral Homes, Inc.</u><br><u>2501 Gwynns Falls PKWY Baltimore, Md. 21216</u>   |  |   |  |                                   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <u>systemic inflammatory response syndrome</u> 1 week<br>Due to (or as a consequence of):<br><br>b. <u>multorgan failure - sepsis</u> 1 week<br>Due to (or as a consequence of):<br><br>c. <u>end stage renal disease</u> 1 month<br>Due to (or as a consequence of):<br><br>d. <u>    </u><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |   |   |   |  |   |  |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>diabetes</u><br><u>hypertension</u>   |   |   |   |   |  |   |  |                                   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |                                   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |   |   |  |   |  |                                   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <u>    </u> |  |   |  |                                   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)<br><u>    </u>   |   | 28b. Time of Injury<br><u>    </u> M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><u>    </u>  |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><u>    </u>   |  |   |  |                                   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |   |   |  |   |  |                                   |  |
| 29b. Signature and title of certifier<br><u>R. Klein MD</u>  |   |   |   | 29c. License number<br><u>AS2402321RK9039</u>   |  | 29d. Date signed (Month, Day, Year)<br><u>February 26, 1997</u>                             |  |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Robyn Klein MD Sinai Hospital of Baltimore</u>  |   |   |   |   |  |   |  |                                   |  |
| 31. Date filed (Month, Day, Year)<br><u>MAR 04 1997</u>  |   |   |   | 32. Registrar's Signature<br><u>[Signature]</u>   |  |   |  |                                   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or funeral home: The law requires that the death certificate be executed within 24 hours of death.  
To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 06277

Reg. No.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>EDWARD LEE JONES SR.</b>                            |   | 2. Date of Death<br>Month <b>MARCH</b> Day <b>1</b> Year <b>1997</b> |  | 3. Time of Death<br><b>6:15 P.M.</b>       |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>808 GOVERNORS BRIDGE ROAD</b> |   | 4b. City, Town, or Location of Death<br><b>DAVIDSONVILLE</b>         |  | 4c. County of Death<br><b>ANNE ARUNDEL</b> |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-62-7837</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>40</b> Yrs.                     | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 8 1956</b>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Wash D.C.</b>                                       |   | Usual Residence of Decedent  |  |  |
| 10a. State<br><b>Md</b>  |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Davidsonville</b>  |  |
| 10e. Street and Number<br><b>808 Governors Bridge Road</b>   |  | 10f. Zip Code<br><b>21035</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Maintenance Engineer</b>   |  |
| 16b. Kind of Business/Industry<br><b>Research PerImmune Inc.</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Everett Barney Jones Jr.</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Patricia Agpoa</b>   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Everett Barney Jones III</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1701 Forrestville Rd., Edgewater, Md 21037</b>  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lakemont Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Davidsonville Md</b>   |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Hardesty Funeral Home, P.A., 12 Ridgely Ave., Annapolis, Md 21401</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Contact Gunshot Wound of Chest</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>S/P Left Leg Amputation (above knee)</b>   |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>3/1/97</b>   |  | 28b. Time of Injury<br><b>1803 P M</b>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><b>self-inflicted gunshot wound</b>  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>808 Governors Bridge Rd Davidsonville, Md</b>   |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>O.C.M.E.</b>   |  |
| 29d. Date signed (Month, Day, Year)<br><b>MARCH 2, 1997</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201</b>  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>  |  | 32. Registrar's Signature<br>   |  |  |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed, it must be filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 10c Per FH Film G745 3-4-97 rja

Certificate of Death

Reg. No.

97 06278

|   |   |  |  |   |   |   |   |  |
|---|---|--|--|---|---|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ANNE K LEVITAS</b>   |  |  |   | 2. Date of Death<br>Month Day Year<br><b>MARCH 1 1997</b>   |   | 3. Time of Death<br><b>9:45AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Genesis ElderCare Randallstown</b>   |  |  |   | 4b. City, Town, or Location of Death<br><b>Randallstown</b>   |   | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-48-1380</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>Sept 15, 1903</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Russia</b>   |  | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Baltimore</b>   |   | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent<br>10a. State<br><b>MD</b>  |  |  |   | 10b. County<br><b>Baltimore</b>   |   | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  |
|   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   | 10e. Street and Number<br><b>6313 Greenspring Ave Apt 304</b>   |   | 10f. Zip Code<br><b>21209</b>   |  |
|   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |
|   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>White</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12</b>   |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>   |  |  |   | 16b. Kind of Business/Industry<br><b>Own Home</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>Abraham Kremen</b>  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rebecca Unobtainable</b>  |  |  |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs Sheila M Oster (Daughter)</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12145 Faulkner Drive, Owings Mills, MD 21117</b>  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington-Chizuk Amuno</b>   |   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |  |   | 22. Name and Address of Facility<br><b>Sol Levinson &amp; Bros.<br/>8900 Reisterstown Rd, Pikesville, MD 21209</b>  |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Coronary - Respiratory arrest</b><br>Due to (or as a consequence of): |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                      |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined               |  |
| 28a. Date of Injury (Month, Day, Year)  |   |  |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred   |   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |   | 29c. License number<br><b>21680</b>   |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>March 1, 1997</b>   |   |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>6717 Poulk Hengst Avenue Baltimore, Maryland 21215</b> |   | 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>                                     |   |  |
| 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  | 33. Registrar's Name<br><b>Julia Davidson-Randall</b>   |   | 34. Registrar's Title<br><b>21215</b>   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

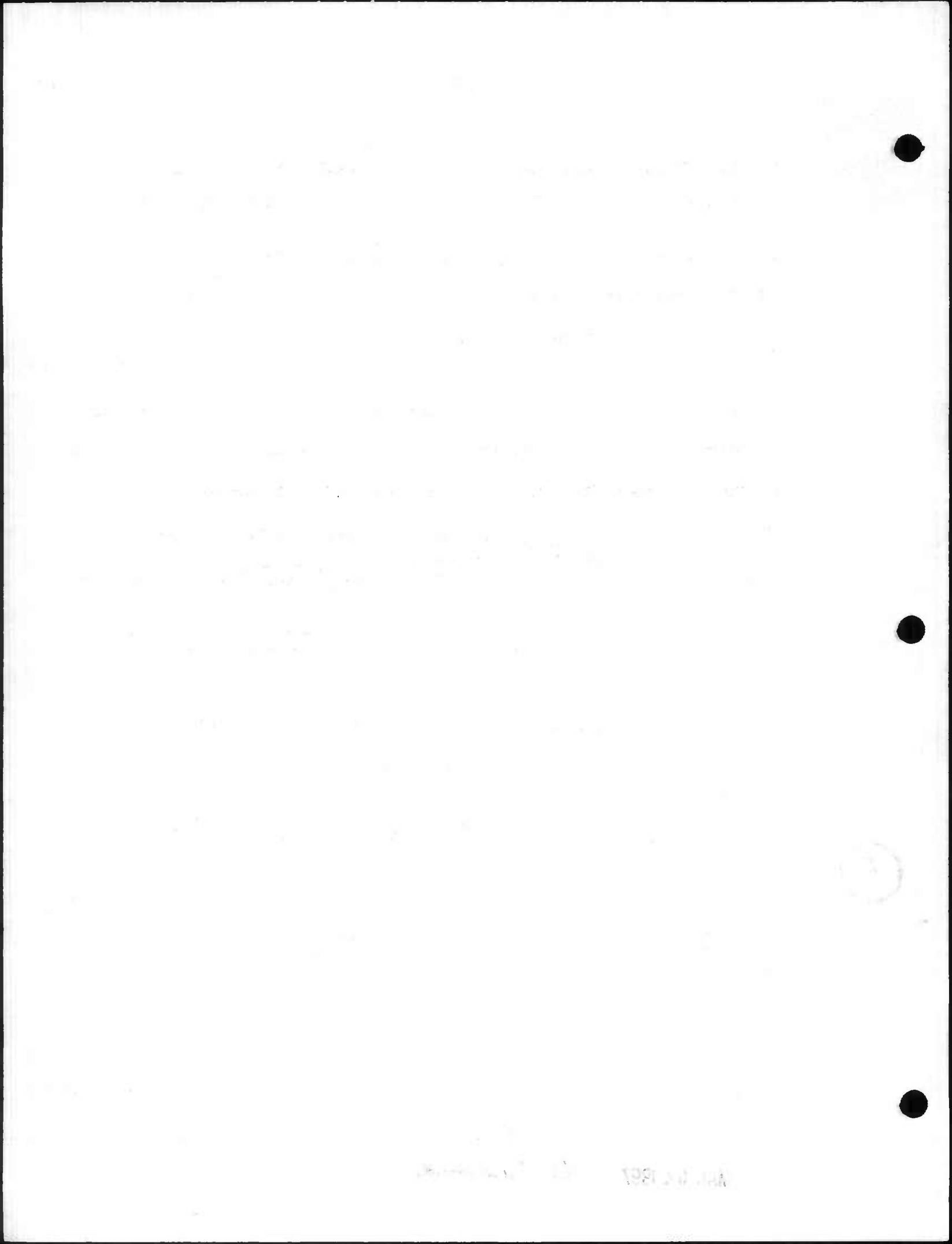
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: To insure that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please forward to the Division of Vital Records.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06279

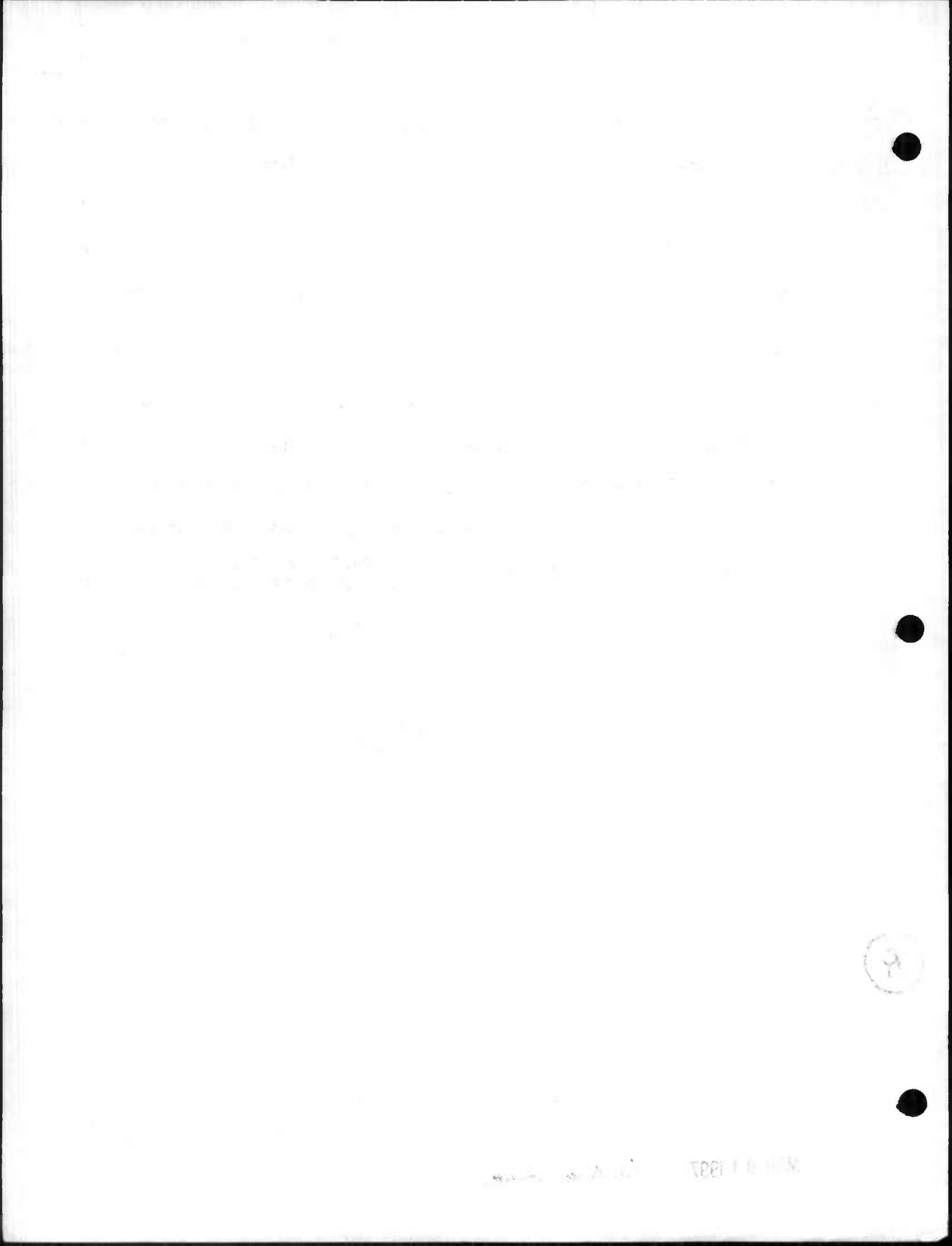
## Certificate of Death

Reg. No.

|  |   |   |  |   |  |  |  |  |  |
|--|---|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Julius Levin</b>                             |   |  |   | 2. Date of Death<br>Month <b>Feb.</b> Day <b>26</b> Year <b>1997</b> |  | 3. Time of Death<br><b>6:10pm</b>                            |  |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>3742 Clarinth Road</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>             |  | 4c. County of Death<br><b>n/a</b>                            |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-03-4063</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.                     |  | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 28, 1908</b> |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                 |   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>n/a</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>              |  |  |
| Usual Residence of Decedent  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>3742 Clarinth Road</b>   |  | 10f. Zip Code<br><b>21215</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Fabric Cutter</b>   |  | 16b. Kind of Business/Industry<br><b>Clothing</b>   |  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Michael Levin</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lena Herr</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Marsha Golub (Niece)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>24 Bellchase Court Baltimore, MD 21208</b>     |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hebrew Young Mens</b>  |  | Date<br><b>2-27-1997</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Ellen Sue Swanson</b>  |   | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>8900 Reisterstown Road Pikesville, MD 21208</b>   |  |   |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>MECOTHELIONA</b><br><br>Due to (or as a consequence of):<br><b>Respiratory failure</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>Pleural effusion</b><br><br>Due to (or as a consequence of):<br><b>Atrial fibrillation</b> |   |   |  |   |  |  |  | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b>  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>              |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   | 29b. Signature and title of certifier<br><b>Julia Swanson-Randall</b>   |  | 29c. License number<br><b>DJ0339</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/27/97</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Nolan Wister, no</b>  |   | 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>   |  | 32. Registrar's Signature<br><b>Julia Swanson-Randall</b>   |  | 33. Address of person who completed cause of death (Item 23a) (Type, Print)<br><b>4000 Old Court Road, Baltimore, MD 21208</b>                     |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06280

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Mable Lewis

2. Date of Death

Month Day Year  
March 2 1997

3. Time of Death

10:00 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

702 Argonne Drive

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

220-40-8439

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
November 25, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

702 Argonne Drive

10f. Zip Code

21218

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James Maruice Beecher

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Frances Reed

19a. Informant's Name/Relationship (Type, Print)

Mr. Roland W. Lewis/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

702 Argonne Drive Baltimore, Maryland 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Peters Church Cemetery

Date

3/5/97

20c. Location - City or Town, State

Queenstown, Maryland

21. Signature of Funeral Service Licensee Mark T. Zavoyna

Mark T. Zavoyna

22. Name and Address of Facility Leonard J. Ruck Funeral Home, Inc.

5305 Harford Road Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Myocardial Infarction  
Due to (or as a consequence of):

b. Coronary Artery Disease  
Due to (or as a consequence of):

c.   
Due to (or as a consequence of):

d.   
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W. M. Smith M.D.

29c. License number

D10809

29d. Date signed (Month, Day, Year)

3/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. M. Smith M.D. 1900 E. No. Pkwy Baltimore 21239

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

Julia Davidson-Pindall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

THE  
OFFICE  
OF THE  
ATTORNEY  
GENERAL  
STATE OF  
NEW YORK  
ALBANY  
JANUARY 10 1901



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06281

## Certificate of Death

Reg. No.

|   |  |  |   |   |  |  |   |  |
|---|--|--|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>OLIVIA LEAVERE</b>  |  |   |   | 2. Date of Death<br>Month <b>February</b> Day <b>28</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>12:57PM</b>                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SINAI HOSPITAL</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>                                       |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-18-4480</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>July 28, 1912 Va.</b>         | 9. Birthplace (State or Foreign Country)   |
|   | Usual Residence of Decedent  |  |   |   |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>N/A</b>   |   | 10c. City, Town or Location<br><b>Baltimore</b>  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|   | 10e. Street and Number<br><b>2457 West Coldspring Lane</b>   |  |   |   | 10f. Zip Code<br><b>21215</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>High School</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Seamstress</b>                      |   | 16b. Kind of Business/Industry<br><b>Raleigh Manufacturer</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Daniel Redcross</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Delphine Foster</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Marian D. Borum sister</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2208 Poplar Grove Street Baltimore, Md. 21216</b>  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest Veterans</b>   |   | Date<br><b>March 6</b>   |  | 20c. Location - City or Town, State<br><b>Owings Mills, Md.</b>         |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br><b>Nutter Funeral Homes, Inc.<br/>2501 Gwynns Falls PKWY Baltimore, Md. 21216</b>  |  |   |  |
|   | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. INTRACEREBRAL HEMORRHAGE</b><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d.</b> |  |   |   |  |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |   |  |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |   |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPERTENSION</b>   |  |  |   |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year) |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred   |  |  |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |   |  |  |   |  |
| 29b. Signature and title of certifier<br><b>Samuel A. Lee, MD</b>   |  |  |   | 29c. License number<br><b>A52402321-SL-9009</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>February 28, 1997</b>                      |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SINAI HOSPITAL</b>   |  |  |   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>   |  |  |   | 32. Registrar's Signature<br>   |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Funeral Director: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

*[Faint, illegible handwritten text]*

SEP 10 1957



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06282

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VALLY M. MARCIANO

2. Date of Death

Month FEBRUARY Day 26, Year 1997

3. Time of Death

3:35 P

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

073-18-3434

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 3, 1923

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2303 Pickwick Road

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Supervisor/Acting Director

16b. Kind of Business/Industry

Medical Social Work

17. Father's Name (First, Middle, Last)

Domenick Louis Scotto

18. Mother's Name (First, Middle, Maiden Surname)

Adele Carmella Laganà

19a. Informant's Name/Relationship (Type, Print)

Gail Roberta Marciano Thies  
daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2527 Cedar Drive Baltimore, MD 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

3/3/97

20c. Location - City or Town, State

Hawthorn, NY

21. Signature of Funeral Service Licensee Dawn F. McDonald

Dawn F. McDonald

22. Name and Address of Facility

MacNabb Funeral Home, P.A.

301 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

8 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Metastatic Breast Cancer

Due to (or as a consequence of):

uncertain

c. Right breast cancer

Due to (or as a consequence of):

10 years

d. Left breast cancer

2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Smoking history

Diabetes

CAD

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
injury28c. Injury at  
Work?

M

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Holly R Dahlgren MD, intern

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

2-26-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Holly R Dahlgren, MD; JOHNS HOPKINS HOSPITAL, 600 N. WOLFE ST, BALTIMORE, MD 21287

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: The death certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature

1921-4-0-1411

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06283

## Certificate of Death

Reg. No.

|   |   |   |  |   |  |  |  |  |
|---|---|---|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>NAOMI MILLER</i>                         |   |  |   | 2. Date of Death<br>Month <i>02</i> Day <i>25</i> Year <i>97</i> |  | 3. Time of Death<br><i>9:35 AM</i>                         |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>FRANKLIN WOODS</i> |   |  |   | 4b. City, Town, or Location of Death<br><i>BALTIMORE</i>         |  | 4c. County of Death<br><i>BALTIMORE</i>                    |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>164-30-5369</i>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><i>59</i> Yrs.  | If Under 1 Year<br>Months Days                                   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><i>AUG. 7, 1937</i> | 9. Birthplace (State or Foreign Country)<br><i>Pennsylvania</i>  |
|   | Usual Residence of Decedent   |   |  |   |  |  |  |  |
| 10a. State<br><i>Md.</i>  |   | 10b. County<br><i>Baltimore</i>   |  | 10c. City, Town or Location<br><i>N/A</i>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br><i>18774 Philadelphia Road</i>  |   |   |  | 10f. Zip Code<br><i>21234</i>   |  | 10g. Citizen of What Country?<br><i>USA</i>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>white</i>                        |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>8</i> College (1-4or 5+)  |   |   |  | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Cab Driver</i>  |  | 16b. Kind of Business/Industry<br><i>Self-employed</i>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><i>Robert Whitsel</i>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Unavailable</i>   |  |  |  |  |
| 19e. Informant's Name/Relationship (Type, Print)<br><i>Dorothy J. Miller - daughter</i>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>33 Marice Circle, Baltimore, Md. 21221</i>  |  |  |  |  |
| 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Meadowridge Memorial Pk.</i>   |  | 20c. Location - City or Town, State<br><i>Elkridge, Md.</i>                                    |  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |   |  | 22. Name and Address of Facility<br><i>Gary L. Kaufman Funeral Home at Meadowridge<br/>7250 Washington Blvd., Elkridge, Md. 21227</i>   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>a. NON SMALL CELL LUNG CANCER</i><br>Due to (or as a consequence of):<br><i>b. SPINAL CORD COMPRESSION</i><br>Due to (or as a consequence of):<br><i>c.</i><br>Due to (or as a consequence of):<br><i>d.</i> |   |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br><i>ONE AND A HALF YEARS</i>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   |   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><i>M</i>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28d. Describe how injury occurred   |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |  |   |  |  |  |  |
| 29b. Signature and title of certifier<br><i>M. Unni. ATTENDING</i>  |   |   |  | 29c. License number<br><i>D51090</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>2/25/97</i>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><i>M. Unni, MD FRANKLIN WOODS, FRANKLIN SQ DR, BALTIMORE 21237</i>  |   |   |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>MAR 04 1997</i>   |   |   |  | 32. Registrar's Signature<br><i>J. Anderson-Randall</i>   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or other institution where the death occurred, this certificate must be completed and filed by the funeral director, page 2 should be detached for use as the burial-transit permit.

To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06284

Items: 23 part I, 27, 28a, b, c, d, e, f per MEO G-745 3/14/97 reb

Certificate of Death

Reg. No.

|   |   |   |  |  |                                |  |  |  |  |
|---|---|---|--|--|--------------------------------|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>EUGENE T. MCDOWELL</b>                       |   |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>28</b> Year <b>1997</b>   |                                | 3. Time of Death<br><b>00:43 A</b>   |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1909 MAULSBY COURT</b> |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |                                | 4c. County of Death<br><b>n/a</b>  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-72-4346</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>37</b> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>MAR. 31, 1959</b> | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  |
|   | Usual Residence of Decedent   |   |  |  |                                |  |  |  |  |
| 10a. State<br><b>MD</b>   |   | 10b. County<br><b>n/a</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |
| 10e. Street and Number<br><b>1909 MAULSBY COURT</b>   |   |   |  | 10f. Zip Code<br><b>21237</b>  |                                | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |  |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 th</b> Collage (1-4 or 5+) <b>-</b>  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>DISABLED</b>   |                                | 16b. Kind of Business/Industry<br><b>LABORER</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>KERMIT DAVIS</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FRANCES BRAXTON</b>  |                                |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MYLES MC DOWELL</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1304 W. LAYFAYETTE AVE., BALTIMORE, MD#17</b>  |                                |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>VOSHALL MEMORIAL GARDENS</b>   |  | Data<br><b>3-6 DUNDALK, MD</b>   |                                | 20c. Location - City or Town, State  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Galvin M. Davis</i>   |   |   |  | 22. Name and Address of Facility<br><b>WM. C. MARCH FH.-1101 E. NORTH AVENUE</b>   |                                |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. NARCOTIC AND ALCOHOL INTOXICATION</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |  |  |                                |  |  | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |  |
|   |   |   |  |  |                                | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   |   |   |  |  |                                |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA                                  |  | Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |                                | 26. Place of Death (Check only one)  |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)<br><b>found 2/28/97</b>  |  | 28b. Time of Injury<br><b>found 12:35</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><b>Subject ingested drugs and alcohol</b>   |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>found at home</b>                                    |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>1909 Maulsby Court Baltimore, Md.</b>   |                                |  |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   | 29b. Signature and title of certifier<br><i>Stephen S. Radentz, MD</i>  |  | 29c. License number<br><b>OCME</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 28, 1997</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201</b>  |   |   |  |  |                                |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>   |   |   |  | 32. Registrar's Signature<br><i>John Davidson-Randall</i>  |                                |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 902-24-0000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Coroner's Office: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06285

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |  |  |  |
|---|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>LOTTIE M. MULL</b>   |  |   |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>28</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>11:29AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>UNIVERSITY OF MARYLAND HOSPITAL</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>n/a</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-74-4240</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>99</b> Yrs. | 8. Date of Birth (Month, Day, Year)<br><b>June 19 1897</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |  |
|   | Usual Residence of Decedent   |  |   |  |   |  |  |  |
| To Be Completed by Funeral Director                                       | 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>n/a</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>3702 St. Victor Street</b>   |  |   |  | 10f. Zip Code<br><b>21225</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>  |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife/domestic</b>            |  | 16b. Kind of Business/Industry<br><b>Home Owner</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner                             | 17. Father's Name (First, Middle, Last)<br><b>Charles Zimmerman</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alice Zepp</b>  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Charles E. Mull (Son)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3702 St. Victor Street Baltimore, Md. 21225</b>   |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Glen Haven Mem. Park</b>   |  | 20c. Location - City or Town, State<br><b>3 1997 Glen Burnie, Md.</b>   |  | 20d. Date<br><b>MARCH</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>McCully Funeral Home of Brooklyn<br/>237 E. Patapsco Ave. Baltimore, Md. 21225</b>   |  |  |  |
| Physician<br>/Medical<br>Examiner   | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Recurrent Pleural Effusion</b><br>Due to (or as a consequence of):<br><b>Lung Mass</b><br>Due to (or as a consequence of):<br><b>Congestive Heart Failure</b><br>Due to (or as a consequence of):                 |  |   |  |   |  |  | Approximate Interval Between Onset and Death   |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |   |  |  |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  |  |  |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  |  |  |
|   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |   |  |  |  |
| State Registrar   | 29b. Signature and title of certifier<br><b>Howard W. Rogers House Staff Physician</b>  |  |   |  | 29c. License number<br><b>P10227</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/28/97</b>  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Howard W. Rogers 22 South Green St. Baltimore, MD.</b>   |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>                   |   |  |   | 32. Registrar's Signature<br>                    |   |  |  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06286

Reg. No.

|  |  |   |  |   |   |  |  |  |  |
|--|--|---|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ELEANORA MOORE</b>                                  |   |  |   | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 27 1997</b> |  | 3. Time of Death<br><b>5:10 PM</b>                       |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>NORTHWEST HOSPITAL CENTER</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>RANDALLSTOWN</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>                  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>228-48-2651</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.              |  | 8. Date of Birth (Month, Day, Year)<br><b>08/23/1910</b> |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |   | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>N/A</b>                                     |  | 10c. City, Town or Location<br><b>Baltimore</b>          |  |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>1109 N. MONROE STREET</b>  |   | 10f. Zip Code<br><b>21217</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                       |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12th</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>   |  | 16b. Kind of Business/Industry<br><b>In Home</b>  |   | 17. Father's Name (First, Middle, Last)<br><b>Pat Reid</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lou Reid</b> |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Naomi Moore</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1109 N. Monroe Street, Balto., MD 21217</b>   |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King Memorial Park</b>  |  | 20c. Location - City or Town, State<br><b>3/3 Randallstown, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Leroy O. Dyett</b>   |  | 22. Name and Address of Facility<br><b>LEROY O. DYETT &amp; SON FUNERAL HOME, P.A.<br/>4600 LIBERTY HEIGHTS AVE., BALTO. 21207</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediata Cause (Final disease or condition resulting in death)<br><b>a. PNEUMONIA</b><br>Due to (or as a consequence of):<br><b>b. CHRONIC OBSTRUCTIVE LUNG DISEASE</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |   | Approximate Interval Between Onset and Death<br><b>4 DAYS</b>  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES, HYPOTHYROIDISM, DEMENTIA</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>                                      |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>MD</b>  |  | 29c. License number<br><b>BC 4439128</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 27, 1997</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THOMAS GEORGE, NORTHWEST HOSPITAL CENTER</b>  |  | 31. Data filed (Month, Day, Year)<br><b>MAR 04 1997</b>   |  | 32. Registrar's Signature<br><b>Judith...</b>   |   | 33. Address of person who completed cause of death (Item 23a) (Type, Print)<br><b>5401 OLD COURT ROAD<br/>RANDALLSTOWN 21133</b>                       |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

97 06287

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nancy Julia Mills

2. Date of Death

March 02, 1997

3. Time of Death

1:20 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Inns of Evergreen-Northwest

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

227-42-5134

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec 26, 1916

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

Yes ☒ No ☐

10e. Street and Number

3009 Carlisle Avenue

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: American Indian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

James Easter

18. Mother's Name (First, Middle, Maiden Surname)

Corrine Travis

19a. Informant's Name/Relationship (Type, Print)

Louise Y. Terry (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4019 West Coldspring La. Balto, Md 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial Park 3/6/97

Date

20c. Location - City or Town, State

Randallstown, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Caple Funeral Service  
5502 Winner Avenue Baltimore, Md. 21215

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Cerebral vascular accident

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerosis  
Diabetes  
Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

DZ7569

29d. Date signed (Month, Day, Year)

3/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allen Hettlemen 1838 Green Tree Rd #300

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or other certifier: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

9

1921

1921

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State of Maryland / Department of Health and Mental Hygiene

97 06288

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sonia

Magnas

2. Date of Death

February 28, 1997

3. Time of Death

1:17 AM

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

None

Funeral  
Director

5. Social Security Number

111-30-7562

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 15, 1910

9. Birthplace (State or Foreign Country)

Russia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1111 University Blvd., West

10f. Zip Code

20902

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Louis Wiener

18. Mother's Name (First, Middle, Maiden Surname)

Libbey Cantor

19a. Informant's Name/Relationship (Type, Print)

Howard L. Magnas, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3 Saddlerock Court, Silver Spring, Maryland 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Har Hemnuchot Cemetery

Date

3/02/1997

20c. Location - City or Town, State

Jerusalem, Israel

21. Signature of Funeral Service Licensee

Donald C. Stottmyer

22. Name and Address of Facility

STEIN HEBREW MEMORIAL FUNERAL HOME, INC.

232 CARROLL STREET, NW, WASHINGTON, DC 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. myocardial infarction

Due to (or as a consequence of):

b. coronary artery disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

one day

29 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

aortic stenosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation8 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Richard A. Hardart M.D.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

February 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard Anthony Hardart M.D. 820 William Street, Baltimore MD 21230

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

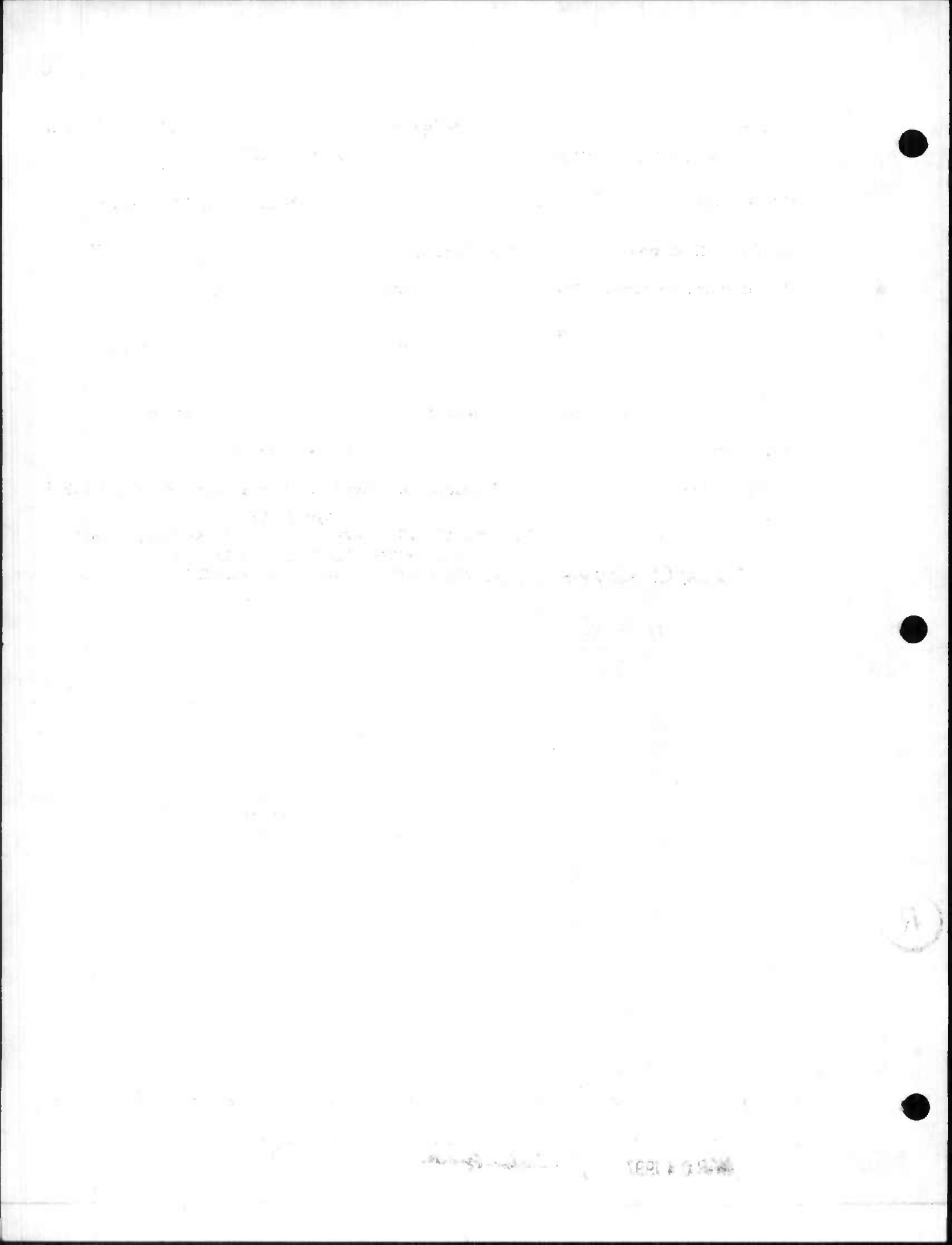
Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 06289

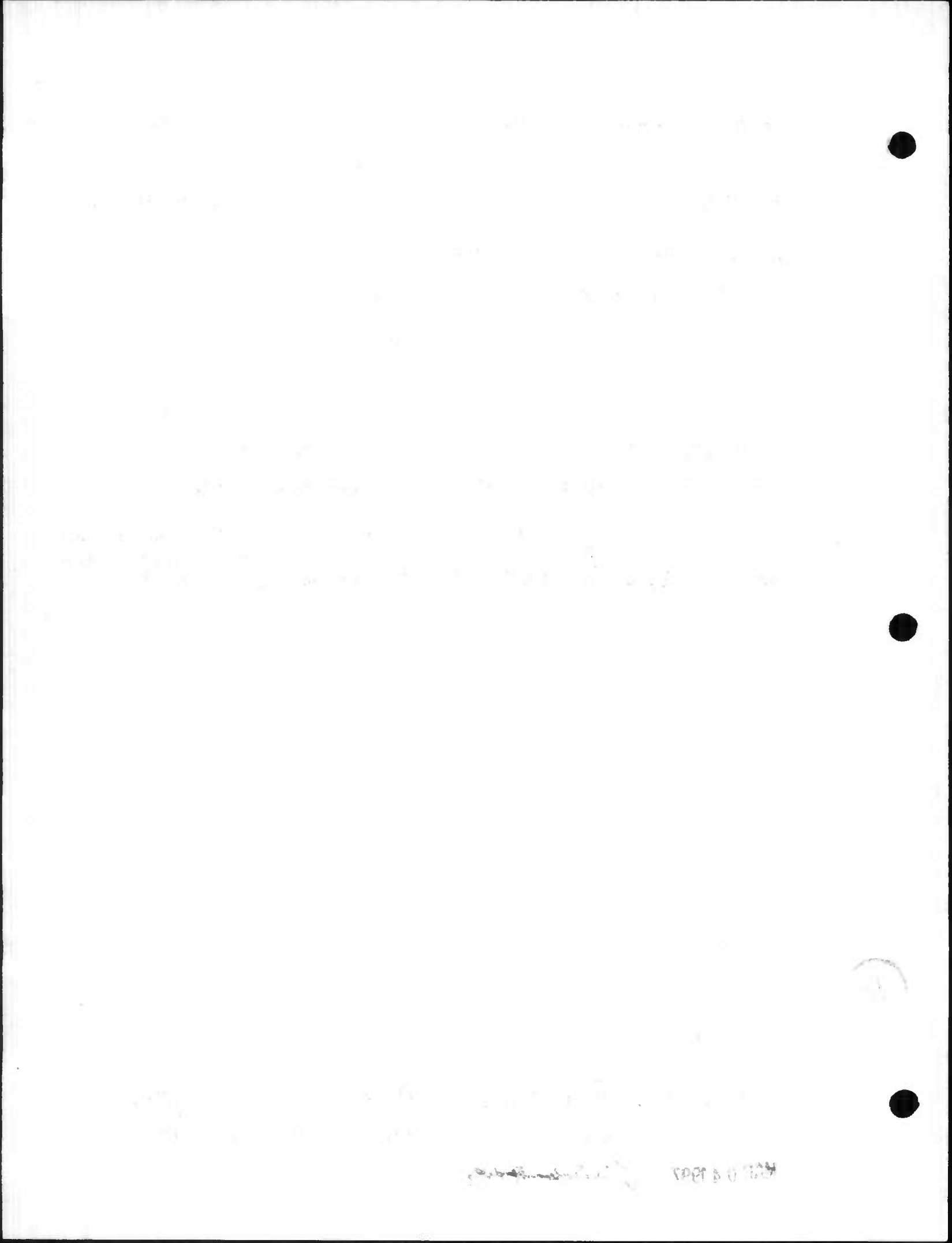
|  |  |  |   |  |  |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>Marie Louise Mace  |  |   |  | 2. Date of Death<br>Month: March Day: 2 Year: 1997   |  |  |  | 3. Time of Death<br>11:45 p.m.   |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br>Stella Maris   |  |   |  | 4b. City, Town, or Location of Death<br>Towson   |  |  |  | 4c. County of Death<br>Baltimore   |  |
| Funeral<br>Director  | 5. Social Security Number<br>213-20-3654   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F XXX  |  | 7. Age (In yrs. last birthday)<br>91 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>June 11, 1905                                 |  | 9. Birthplace (State or Foreign Country)<br>Illinois   |  |
|  | Usual Residence of Decedent  |  |   |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br>Maryland   |  | 10b. County<br>Baltimore  |  | 10c. City, Town or Location<br>Towson  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br>2300 Dulaney Valley Road   |  |   |  | 10f. Zip Code<br>21204   |  |  |  | 10g. Citizen of What Country?<br>USA   |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary 12 Secondary (0-12) Collage (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker   |  |  |  | 16b. Kind of Business/Industry<br>Own Home   |  |
|  | 17. Father's Name (First, Middle, Last)<br>Frank Thomas Mace   |  |   |  | 18. Mother's Name (First, Middle, Maiden Sumama)<br>Cora Summers   |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Joseph C. Mace Nephew  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1106 Metfield Road Towson, Maryland 21286   |  |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Woodlawn Cemetery  |  | 20c. Location - City or Town, State<br>3/4/97 Woodlawn, Maryland                     |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Donnis Stephen Kenaker</i>   |  |   |  | 22. Name and Address of Facility<br>Mitchell-Wiedefeld Home<br>6500 York Road Baltimore, Maryland 21212  |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Arteriosclerotic Cardiovascular Disease<br>Due to (or as a consequence of):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |  |  |  |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.   |  |   |  |  |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner                                    | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |  |  |  |  |  |  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |  |  |
|  | 24b. Were autopsy findings available prior to completion of causa of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |  |  |  |  |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |  |  |
|  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|  | 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |  |  |
|  | 29b. Signature and title of certifier<br><i>Kendall Faulkner</i>   |  |   |  | 29c. License number<br>D25643  |  |  |  | 29d. Date signed (Month, Day, Year)<br>3/3/97  |  |
| State<br>Registrar   | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br>Kendall Faulkner, M.D. 2300 Dulaney Valley Road, Towson, MD 21204  |  |   |  |  |  |  |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br>MAR 04 1997   |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified immediately.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Autopsy Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06290

## Certificate of Death

Reg. No.

|  |   |   |   |  |   |  |  |  |  |  |  |
|--|---|---|---|--|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Thelma Warren Michael                     |   |   |  |   |  | 2. Date of Death<br>Month Day Year<br>March 1, 1997                                  |  | 3. Time of Death<br>4:30A  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Lorien Nursing Home |   |   |  |   |  | 4b. City, Town, or Location of Death<br>Columbia                                     |  | 4c. County of Death<br>Howard  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>212-76-2231  |   | 8. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>87 Yrs. |  | If Under 1 Year<br>Months Days   |  | If Under 24 Hrs.<br>Hours Min.   |  |  |
|  | Usual Residence of Decedent   |   | 10a. State<br>Maryland  |  | 10b. County<br>Prince George              |  | 10c. City, Town or Location<br>Laurel  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br>252 Old Line Avenue  |   | 10f. Zip Code<br>20724  |   | 10g. Citizen of What Country?<br>USA       |   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>2   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker |   | 16b. Kind of Business/Industry<br>Own Home |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Purnell John Warren   |   |   |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Margaret Luckham  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Joyce Michael Weesner DTR  |   |   |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>252 Old Line Avenue Laurel Maryland 20724   |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Parkwood Cemetery   |  |   | Data<br>3/5/97   |  | 20c. Location - City or Town, State<br>Baltimore, Maryland   |  |  |  |
| 21. Signature of Funeral Service/Licensee<br><i>Rennis Wiedefeld</i>   |   |   |   |  |   | 22. Name and Address of Facility<br>Mitchell-Wiedefeld Home<br>6500 York Road Baltimore, Maryland 21212  |  |  |  |  |  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Pneumonia</i><br>Due to (or as a consequence of):<br>b. <i>Alzheimer's Dementia</i><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |  |   |  |  |  |  | Approximate Interval Between Onset and Death<br>Days<br>Years  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|  |   |   |   |  |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M                  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |
|  |   |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |   |  |   |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |   |   |   |  |   | 29c. License number<br>D22856  |  | 29d. Date signed (Month, Day, Year)<br>March 1, 1997   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>JERRY L. LEVIN, MD 11055 Little Patuxent Pkwy, Columbia, MD 21044  |   |   |   |  |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 04 1997   |   |   |   |  |   |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician  
/Medical  
Examiner

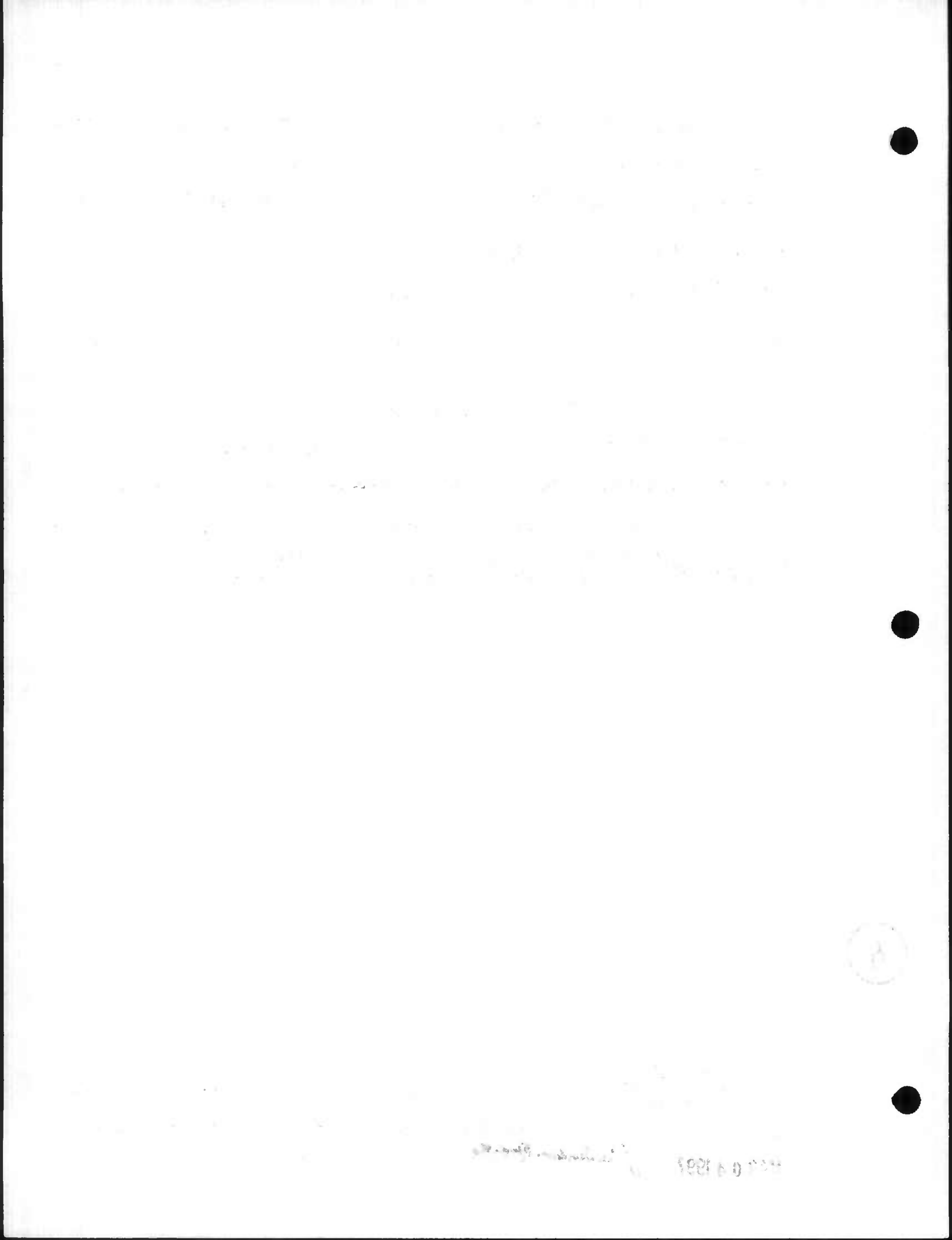
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To the Funeral Director: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

14

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06291

## Certificate of Death

Reg. No.

|   |   |  |   |   |  |                                      |   |  |  |  |  |
|---|---|--|---|---|--|--------------------------------------|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>BESSYE NEWMAN</b>                                |  |   |   | 2. Date of Death<br>Month <b>FEB</b> Day <b>26</b> Year <b>1997</b>  |                                      | 3. Time of Death<br><b>6 AM</b>   |  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>LEVINDALE NURSING HOME</b> |  |   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |                                      | 4c. County of Death<br><b>N/A</b>   |  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-32-9807</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.       | 8. Date of Birth (Month, Day, Year)<br><b>DEC. 25, 1907</b>                                 |  | 9. Birthplace (State or Foreign Country)<br><b>CHICAGO, IL</b> |  |  |
|   | Usual Residence of Decedent   |  |   |   |  |                                      |   |  |  |  |  |
| 10a. State<br><b>MD</b>   |   |  | 10b. County<br><b>BALTIMORE</b>   |   | 10c. City, Town or Location<br><b>BALTIMORE</b>  |                                      |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br><b>6990 MARSUE DRIVE #1A</b>  |   |  |   |   | 10f. Zip Code<br><b>21215</b>  |                                      | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                      |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collage (1-4or 5+) <b></b>   |   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEWIFE</b> |  |                                      | 16b. Kind of Business/Industry<br><b>OWN HOME</b>   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>JACOB ABRAHAM</b>   |   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>HATTYE STERN</b>   |                                      |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ARTHUR J. NEWMAN / SON</b>   |   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6106 BUCKINGHAM MANOR DR. BALTIMORE, MD 21210</b>  |                                      |   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BALTIMORE HEBREW</b>   |   |  | Data<br><b>2/28/97</b>               |   | 20c. Location - City or Town, State<br><b>BALTIMORE, MD</b>                                    |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |  |   |   | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>8900 Reisterstown Road Pikesville, MD 21208</b>  |                                      |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. RESPIRATORY FAILURE</b><br>Due to (or as a consequence of):<br><b>b. SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |   |   |  |                                      |   |  |  | Approximate Interval Between Onset and Death<br><b>TWO WEEKS</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |   |  |                                      |   |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |   |   |  |                                      |   |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                                      |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |                                      |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |                                      | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                              |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |  | 29b. Signature and title of certifier<br><br><b>ATTENDING PHYSICIAN</b>  |   |  | 29c. License number<br><b>225610</b> |   | 29d. Date signed (Month, Day, Year)<br><b>FEB. 26. 1997</b>                                    |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>LEVINDALE 2434 WEST BELVERDERE AVENUE BALTIMORE MD 21215</b>   |   |  |   |   |  |                                      |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>   |   |  | 32. Registrar's Signature<br>  |   |  |                                      |   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This certificate must be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the study and the objectives of the research.

2. The second part of the report is a detailed description of the methodology used in the study. It includes information about the sample size, the data collection methods, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes tables, figures, and text describing the findings of the research.

4. The fourth part of the report is a discussion of the results and their implications. It includes a comparison of the findings with previous research and a discussion of the limitations of the study.

5. The fifth part of the report is a conclusion and a summary of the findings. It includes a final statement about the results of the study and a recommendation for further research.

6. The sixth part of the report is a list of references. It includes a list of all the sources used in the study, including books, articles, and other documents.

7. The seventh part of the report is an appendix. It includes any additional information that is relevant to the study, such as raw data, questionnaires, and other documents.

8. The eighth part of the report is a final statement. It includes a final statement about the results of the study and a recommendation for further research.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06292

Physician  
(Medical  
Examiner)

1. Decedent's Name (First, Middle, Last)

Joseph L. Peterson, Sr.

2. Date of Death

March

Day

1

Year

1997

3. Time of Death

1:10 AM

4a. Facility Name (If not institution, give street and number)

Colonial Manor

4b. City, Town, or Location of Death

Linthicum

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

216-01-2819

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

December 3, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2669 St. Benedicts Street

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Driver

16b. Kind of Business/Industry

Meat Packing

17. Father's Name (First, Middle, Last)

Frank A. Peterson

18. Mother's Name (First, Middle, Maiden Surname)

Susann Tiechman

19a. Informant's Name/Relationship (Type, Print)

Joseph L. Peterson, Jr., son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8680 Concord Drive, Jessup, MD 20794

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Meadowridge Memorial Park

Date

3/4/97

20c. Location - City or Town, State

Elkridge, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gary L. Kaufman Funeral Homes

7250 Washington Blvd., Elkridge, MD 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Chronic Obstructive Lung Disease

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Endstage Cardiomyopathy

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of injury  
(Month, Day Year)28b. Time of  
injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

MD

29c. License number

D38662

29d. Date signed (Month, Day, Year)

3/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard J. Walsh, M.D. 4660 Wilkens Avenue Baltimore, MD 21229

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
(Medical  
Examiner)

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner



9



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I, 27 per ME0 G-745 3/21/97 re: **Certificate of Death**

Reg. No.

97 06293

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,  
To the Hospital or Coroner: The law requires that the death certificate be executed within 24 hours of the death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |                                |  |  |  |  |
|---|--|---|--|--|--------------------------------|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Garry Pinchback</b>  |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>27</b> Year <b>1997</b>   |                                | 3. Time of Death<br><b>7:25 A.M.</b>   |  |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Good Samaritan Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |                                | 4c. County of Death<br><b>N/A</b>  |  |  |  |
| 5. Social Security Number<br><b>219-62-0587</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>39</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>11/19/1957</b>   |  |  |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |  |                                |  |  |  |  |
| Usual Residence of Decedent   |  |   |  |  |                                |  |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |
| 10e. Street and Number<br><b>1605 Chilton Street</b>  |  |   |  | 10f. Zip Code<br><b>21218</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>N/A</b>  |                                | 16b. Kind of Business/Industry<br><b>N/A</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>George Pinchback</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Evelyn Cole</b>  |                                |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Margaret Saunders</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1605 Chilton Street, Baltimore, MD 21218</b>   |                                |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Voshell Memorial Garden</b>  |  | Data<br><b>3/6</b>   |                                | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Leroy O. Dyett</b>  |  |   |  | 22. Name and Address of Facility<br><b>LEROY O. DYETT &amp; SON FUNERAL HOME, P.A.<br/>4600 LIBERTY HEIGHTS AVE., BALTO. 21207</b>   |                                |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. PULMONARY THROMBOEMBOLUS</b><br>Due to (or as a consequence of):<br><br><b>b.</b> Due to (or as a consequence of):<br><br><b>c.</b> Due to (or as a consequence of):<br><br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |                                |  |  | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |  |
|   |  |   |  |  |                                | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |
|   |  |   |  |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |
|   |  | 28d. Describe how Injury occurred   |  |  |                                | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
|   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |                                |  |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><b>Stephen S. Radentz, MD</b>  |  | 29c. License number<br><b>O.C.M.E.</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>February 28, 1997</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Stephen S. Radentz, MD, 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |  |  |                                |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>   |  |   |  | 32. Registrar's Signature<br><b>Julie Davidson-Randall</b>   |                                |  |  |  |  |

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06294

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SADIE E. PRICE

2. Date of Death

FEBRUARY 27 1997 12:55 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

BON SECOUR HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

5. Social Security Number

215-14-3141

6. Sex

1 ☐ M 2 ☒ X

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUNE 5 1916

9. Birthplace (State or Foreign Country)

MARYLAND

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

342 BLOOM STREET

10f. Zip Code

21217

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8th grade

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

DOMESTIC

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

HENRY WHITE

18. Mother's Name (First, Middle, Maiden Surname)

ESTELLA WHITE

19a. Informant's Name/Relationship (Type, Print)

George Price/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

342 Bloom Street, Baltimore, Maryland 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

GARRISON FOREST VETERANS 3-5-97 OWINGS MILLS, MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WILLIAM C. BROWN COMMUNITY F/H  
1206 W. NORTH AVENUE23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

b. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Arteriosclerotic Cardiovascular Diseases

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
Investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

R. M. SHAN MO

29c. License number

D19608

29d. Date signed (Month, Day, Year)

February 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. M. SHAN MO, Bon Secour Hospital, Baltimore, MARYLAND

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Papers 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This certificate is to be completed by the physician or other qualified person who requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

*[Faint, illegible text covering the majority of the page, possibly bleed-through from the reverse side.]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06295

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,


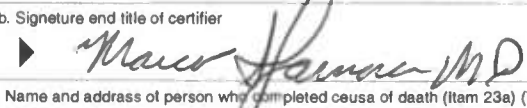
To the Hospital or Attending Physician: The attending physician must sign that the death certificate has been executed within 24 hours after death.

To the Funeral Director: After this certificate is signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

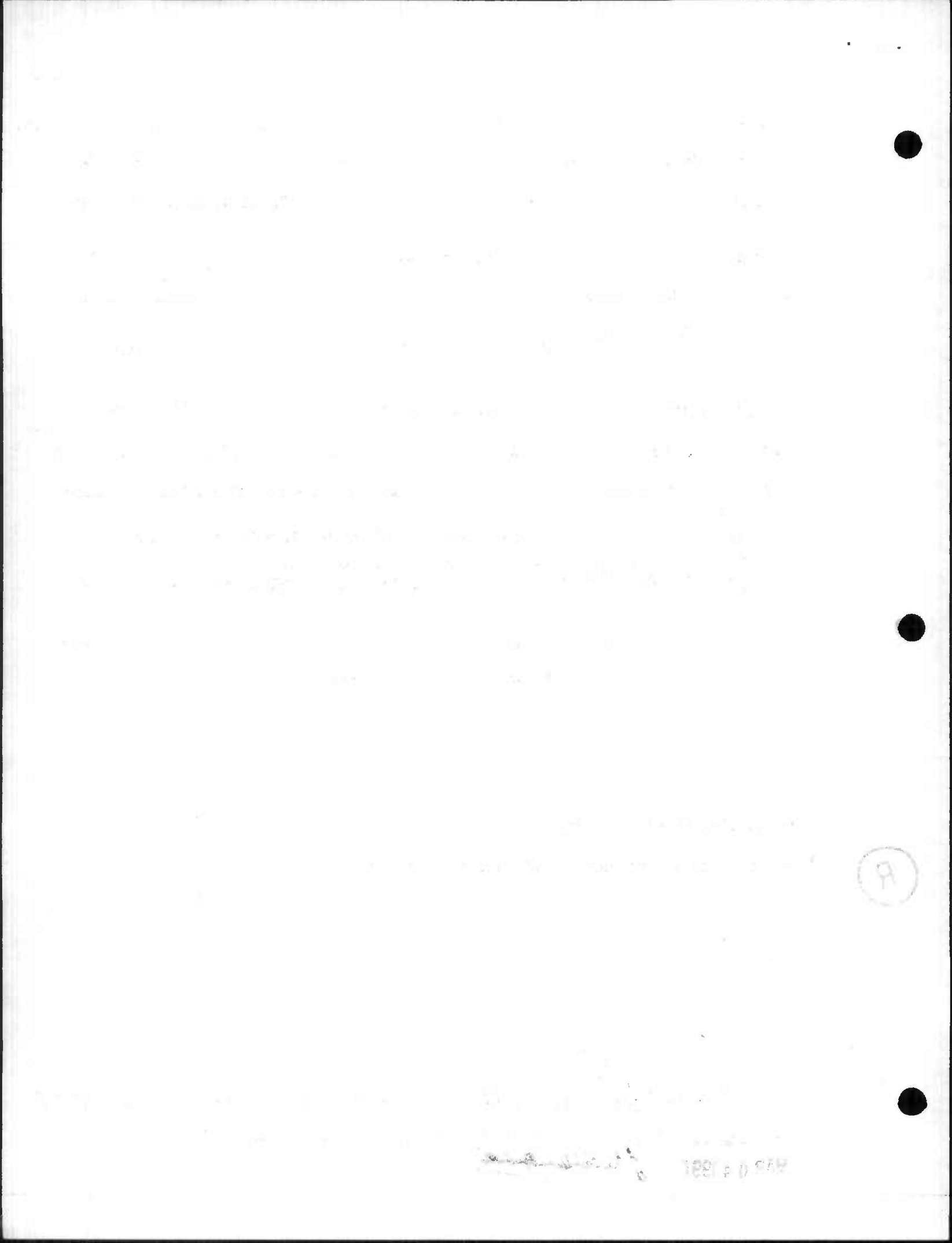
Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Vernon PRICE</b>   |  | 2. Date of Death<br>Month Day Year<br><b>February 28, 1997</b>  |   | 3. Time of Death<br><b>11:30 A.M.</b>  |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital Center</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Rosedale</b>   |  | 4c. County of Death<br><b>Baltimore County</b>              |
| 5. Social Security Number<br><b>213-10-2734</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>April 9, 1920</b> |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |   |   |  |   |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>N/A</b>   |   | 10c. City, Town or Location<br><b>Baltimore City</b>   |   |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   |  |   |
| 10e. Street and Number<br><b>5914 Plainfield Avenue</b>   |  |   | 10f. Zip Code<br><b>21206</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>       |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1944-1946</b>  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |   |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b><br>College (1-4 or 5+) <b>Field Engineer</b>   |  |   | 16. Kind of Business/Industry<br><b>Missile Sites</b>   |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Leroy (NMI) Price</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Reba (NMI) Middleton</b>  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Irene M. Price /Wife</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5914 Plainfield Avenue, Baltimore, Maryland 21206</b> |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Crematory, Inc.</b>   |   | 20c. Location - City or Town, State<br><b>Beltsville, Maryland</b>   |   |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>John C. Miller, Inc.<br/>6415 Belair Road, Baltimore, Maryland 21206</b>   |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Renal failure</b><br>Due to (or as a consequence of):<br><b>Atherosclerotic coronary vascular disease</b><br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>1 month</b> |  |   |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive cardiomyopathy</b><br><b>Prostate cancer, diabetes mellitus, hypertension</b>   |  |   |   |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |   |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |  |   |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D40819</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>February 28, 1997</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Marco Zamora 9000 Franklin Square Dr. Baltimore, Maryland 21237</b>  |  |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>   |  |   |   |  |   |

State  
Registrar



97 06296

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SADIE M. REMESCH</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>MARCH</b> DAY <b>2</b> YEAR <b>1997</b>  |  |   |  | 3. TIME OF DEATH<br><b>6 11 PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-24-9711</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>90</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>  |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>MAR 23, 1906</b>  |  |  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Carroll General Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Westminster</b>   |  |   |  | 9c. COUNTY OF DEATH<br><b>Carroll</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Carroll</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Finksburg</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |
| 10e. STREET AND NUMBER<br><b>2825 Lawndale Road</b>  |  |  |  | 10f. ZIP CODE<br><b>21048</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                               |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Harry Ryan</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sadie Cooke</b>   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Frances R. Rumbly/daughter</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2401 Walden Way Marriottsville, MD 21104</b>  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc. 3/3/97</b>   |  |   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>                                 |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>George E. MacNabb</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Cremation Society of Maryland, Inc.<br/>299 Frederick Rd. Baltimore, MD 21228</b>  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   |  | Approximate interval Between Onset and Death<br><b>6 Days</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPOHYPOVISA, PREVIOUS MYOCARDIAL INFARCTION</b>  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Don H. Schaefer MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>028221</b>  |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>MARCH 2, 1997</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>200 MEMORIAL AVENUE, WESTMINSTER MARYLAND 21157</b>  |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 04 1997</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>J. A. Davidson-Rindell</b>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 26 indicates, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



(59)

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Handwritten text, possibly a date or initials, located at the bottom right of the page.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06297

Item 19a Per FH Film G:745 3-4-97 rja

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

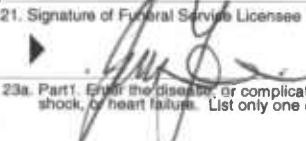
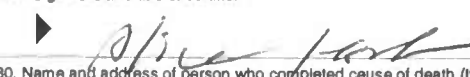
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After a certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Barbara Rosen</b>   |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>25</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>5:02 pm</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Northwest Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| 5. Social Security Number<br><b>217-46-1192</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In y/s. last birthday)<br><b>91</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>AUG. 14, 1905</b>                          |  |
| 9. Birthplace (State or Foreign Country)<br><b>RUSSIA</b>  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE</b>                                      |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>3809 CLARKS LANE APT. 102</b>  |  | 10f. Zip Code<br><b>21215</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                       |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>              |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEWIFE</b>                     |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>ISRAEL</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CHANNAH YENTE</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ELLIS H. MITCHELL I. ROSEN / SON</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>107 WEST MADISON STREET BALTIMORE, MD, 21201</b>   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>(OHEL YAAKOV) BETH ISRL</b>  |  | 20c. Location - City or Town, State<br><b>2/28/97 BALTIMORE, MD</b>  |  | 20d. Date  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 Reisterstown Road Pikesville, MD 21208</b>  |  |  |  |
| 23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Septic</b><br>Due to (or as a consequence of):<br>b. <b>pneumonia</b><br>Due to (or as a consequence of):<br>c. <b>Respiratory failure</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>1143974</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>February 25, 1997</b>                      |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Northwest Hospital - Reisterstown, Ind. Alice Hirsch</b>  |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>  |  |   |  | 32. Registrar's Signature<br>   |  |  |  |

State  
Registrar

(2)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06298

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FANNIE

ROSENBLATT

2. Date of Death

Month Day Year

FEBRUARY 27, 1997

3. Time of Death

03:35 AM

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

Funeral  
Director

5. Social Security Number

214-01-9225

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

NOV. 29, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Eldersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2159 Sooner Court

10f. Zip Code

21784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Hyman

18. Mother's Name (First, Middle, Maiden Surname)

Rainess

Beulah

Ashman

19a. Informant's Name/Relationship (Type, Print)

Mr. Michael N. Rosenblatt (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2159 Sooner Court Eldersburg, MD 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moses Montefiore

Date

2-28-97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 Reisterstown Road Pikesville, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. PLEURAL FIBROSIS

Due to (or as a consequence of):

c. METASTATIC OVARIAN CANCER

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

7 days

1 year

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEPSIS, COPO, CEREBROVASCULAR ACCIDENT

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier:

[Signature]

29c. License number

AS 2402321 EC 9005

29d. Date signed (Month, Day, Year)

2/27/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERIC J. CARR, MD SINAI HOSPITAL OF BALTIMORE

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This certificate must be signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

THE UNITED STATES OF AMERICA  
DO hereby certify that  
[Name] is a citizen of the United States of America  
and is entitled to the rights and privileges of citizenship.

(R)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06299

## Certificate of Death

Reg. No.

|  |  |  |   |  |   |  |   |  |
|--|--|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Rose Ring</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>Feb. 28, 1997</b>  |  | 3. Time of Death<br><b>9:15am</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Pikesville Nursing Home</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Pikesville</b>   |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-74-1032</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>APR. 16, 1906</b>                                 |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>GEORGIA</b>   |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  |
| To Be Completed by<br>Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>7200 CHALKSTONE DR, APT. T-4</b>   |  | 10f. Zip Code<br><b>21208</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collega (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>                     |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>SOLOMON SEGAL</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>JENNIE SNETMAN</b>  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>JUDY LAPIDES (DAUGHTER)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>145 JUMPERS LANE, BALTIMORE, MD 21208</b>   |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Har Sinai</b>  |  | 20c. Location - City or Town, State<br><b>Owings Mills, MD</b>  |  | 20d. Date<br><b>3-3-97</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>8900 Reisterstown Road Pikesville, MD 21208</b>   |  |   |  |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Bowel OBSTRUCTION</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |  |   |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |   |  |   |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |   |  |   |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 28d. Describe how injury occurred  |  |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |
|  | 29b. Signature and title of certifier<br><i>Tasneem Lakhani</i>  |  |   |  | 29c. License number<br><b>D 28595-</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/28/97</b>                                       |  |
|  | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>TASNEEM LAKHANI, 7220 PARK HEIGHTS AVE, BALD MD 21208</b>   |  |   |  |   |  |   |  |
|  | 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>  |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |  |
|  | State Registrar  |  |   |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 18,19b Per FH Film G745 3-7-97 rja

## Certificate of Death

97 06300

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anna E. Shire

2. Date of Death

Month  
MarDay  
3Year  
1997

3. Time of Death

3:00 PM

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

213-30-2583

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MAR 4, 1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

5202 Greenwich Avenue

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Becker

18. Mother's Name (First, Middle, Maiden Surname)

Magdalena EICHHOF  
-Madeline Eichhoff

19a. Informant's Name/Relationship (Type, Print)

Andrew Shire/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8309  
8308 Silver Trumpet Dr. Columbia, MD 21045

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory, Inc. 3/4/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.  
299 Frederick Rd. Baltimore, MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. Intracranial Bleed  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

1 day

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Hypertension  
Due to (or as a consequence of):

10 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Multiple Sclerosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Steven Geller MD

29c. License number

d34613

29d. Date signed (Month, Day, Year)

Mar 4, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven Geller MD 9501 Old Annapolu Rd Ellicott City MD 21042

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

Steven Geller

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

9

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

VECTA 2.16.22

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State of Maryland / Department of Health and Mental Hygiene

97 06301

## Certificate of Death

Reg. No.

|  |  |  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>MARY Ann SCOTT</i>  |  |  |  | 2. Date of Death<br>Month <i>March</i> Day <i>19</i> Year <i>1997</i>  |  |  |  | 3. Time of Death<br><i>6:47A</i>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>BON SECOUR HOSPITAL</i>   |  |  |  | 4b. City, Town, or Location of Death<br><i>BALTIMORE</i>   |  |  |  | 4c. County of Death<br><i>n/a</i>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>247-54-5620</i>  |  | 6. Sex<br><i>1 M 2 F</i>   |  | 7. Age (In yrs. last birthday)<br><i>95</i> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><i>SEPT. 7, 1901</i>                  |  | 9. Birthplace (State or Foreign Country)<br><i>S. CAROLINA</i>  |  |
|  | Usual Residence of Decedent  |  |  |  |  |  |  |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><i>MD</i>  |  | 10b. County<br><i>n/a</i>  |  | 10c. City, Town or Location<br><i>BALTIMORE</i>  |  |  |  | 10d. Inside City Limits<br><i>XX</i> Yes <i>2</i> No  |  |
|  | 10e. Street and Number<br><i>2218 CALLOW AVENUE</i>  |  |  |  | 10f. Zip Code<br><i>21217</i>  |  | 10g. Citizen of What Country?<br><i>UNITED STATES</i>                        |  |   |  |
|  | 11. Marital Status<br><i>1</i> Never Married <i>2</i> Married<br><i>X</i> Widowed <i>4</i> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><i>1</i> Yes <i>2</i> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><i>1</i> Yes <i>X</i> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>BLACK</i>      |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>3rd</i> College (1-4 or 5+) <i>-</i>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>DISABLED</i>   |  |  |  | 16b. Kind of Business/Industry<br><i>LABORER</i>                             |  |   |  |
| To Be Completed by Physician/Medical Examiner                                | 17. Father's Name (First, Middle, Last)<br><i>JANUARY SCOTT</i>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>ALICE WOODS</i>  |  |  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><i>EDITH FULTON</i>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2218 CALLOW AVENUE, BALTIMORE, MD #17</i>        |  |  |  |   |  |
|  | 20a. Method of Disposition<br><i>1</i> Burial <i>2</i> Cremation <i>3</i> Removal from State<br><i>4</i> Donation <i>5</i> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>KING MEMORIAL PAK</i>   |  | Date<br><i>3-7-97</i>  |  | 20c. Location - City or Town, State<br><i>RANDALLSTOWN, MD</i>               |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br><i>WM. C. MARCH FH.-1101 E. NORTH AVENUE</i>   |  |  |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><i>MASSIVE MYOCARDIAL INFARCTION</i>  |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><i>3-2-97</i>   |  |
|  | Immediate Cause (Final disease or condition resulting in death)<br><i>Due to (or as a consequence of):</i><br><i>Myocardial Infarction</i>   |  |  |  |  |  |  |  |   |  |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>Due to (or as a consequence of):</i><br><i>DEMENTIA</i>   |  |  |  |  |  |  |  |   |  |
|  |  |  |  |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner                                | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><i>1</i> Yes <i>2</i> No <i>3</i> Probably <i>4</i> Unknown |  |
|  |  |  |  |  |  |  |  |  | 24a. Was an autopsy performed?<br><i>1</i> Yes <i>2</i> No  |  |
|  |  |  |  |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><i>1</i> Yes <i>2</i> No               |  |
|  |  |  |  |  |  |  |  |  |   |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020 | 25. Was case referred to medical examiner?<br><i>1</i> Yes <i>2</i> No   |  | 26. Place of Death (Check only one)<br>Hospital: <i>1</i> Inpatient <i>2</i> ER/Outpatient <i>3</i> DOA Other: <i>4</i> Nursing Home <i>5</i> Residence <i>6</i> Other (Specify) |  |  |  |  |  |   |  |
|  | 27. Manner of Death<br><i>1</i> Natural <i>5</i> Pending investigation<br><i>2</i> Accident <i>6</i> Could not be determined<br><i>3</i> Suicide <i>4</i> Homicide   |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury<br><i>M</i>  |  | 28c. Injury at Work?<br><i>1</i> Yes <i>2</i> No                             |  | 28d. Describe how injury occurred   |  |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |  |
|  | 29a. Certifier (Check only one)<br><i>1</i> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><i>2</i> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>[Signature]</i>  |  | 29c. License number<br><i>DI 3248</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>3-2-97</i>                         |  |   |  |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>ATINA L. S. S. H. 1 E. CHADLE ST. APT. 601 BALTIMORE MD 21202</i>   |  |  |  |  |  |  |  |   |  |
|  | 31. Date filed (Month, Day, Year)<br><i>MAR 04 1997</i>  |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |  |  |  |   |  |





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State of Maryland / Department of Health and Mental Hygiene  
Item % PerFH Film G 745 3-4-97 rja

## Certificate of Death

Reg. No.

97 06302

|   |  |   |   |   |  |  |   |
|---|--|---|---|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Dennis Robert Sigai, Sr.</b>  |   |   | 2. Date of Death<br>Month <b>March</b> Day <b>2</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>5:50 A.M.</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Fallston General Hospital</b>   |   |   | 4b. City, Town, or Location of Death<br><b>Fallston</b>   |  | 4c. County of Death<br><b>Harford</b>  |   |
| Funeral<br>Director   | 5. Social Security Number <b>0883</b><br><b>216-40-0338</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>54</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>JUL 1, 1942</b>               |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   |   |   |  |  |   |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |   |   |   |  |  |   |
|   | 10e. State<br><b>MD</b>  | 10b. County<br><b>Harford</b>   | 10c. City, Town or Location<br><b>Joppa</b>   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
|   | 10e. Street and Number<br><b>739 Joppa Farm Road</b>   |   |   | 10f. Zip Code<br><b>21085</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Drywall Finisher</b>              |   | 16b. Kind of Business/Industry<br><b>Construction</b>  |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>John Leo Sigai</b>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rosalie Hoerner</b>   |  |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Patricia A. Sigai / Spouse</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2947 Cornwall Road, Apt. 2, Dundalk, MD 21222</b> |  |  |   |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc. 03/03/97</b>                                   |   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |  |   |
|   | 21. Signature of Funeral Service Licensee<br><b>George E. MacNabb</b>  |   | 22. Name and Address of Facility<br><b>Cremation Society of Md., Inc.<br/>299 Frederick Road Baltimore, MD 21228</b>                              |   |  |  |   |
|   | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>myocardial infarction</b><br>Due to (or as a consequence of):<br><b>coronary artery disease</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>morbid obesity, pulmonary hypertension, sepsis with cellulitis, atrial fibrillation, congestive heart failure</b> |   |   |   |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>morbid obesity, pulmonary hypertension, sepsis with cellulitis, atrial fibrillation, congestive heart failure</b>  |  |   |   |   |  |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |   |   |  |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |   |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |   |  |  |   |
| 29b. Signature and title of certifier<br><b>Hung Jun Kim</b>  |  | 29c. License number<br><b>D37364</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>March 2, 1997</b>   |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>19 Walnut Lane, Aberdeen, Maryland</b>   |  |   |   |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>   |  | 32. Registrar's Signature<br><b>Jake Davidson-Randall</b>   |   |   |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be delivered for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

Item 19 b Per FH Film G745 3-4-97 rja

## Certificate of Death

97 06303

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ETHEL SHOHAM

2. Date of Death  
Month Day Year  
February 26 19973. Time of Death  
3 AM

4a. Facility Name (If not institution, give street and number)

LEVINDALE NURSING HOME

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

213-44-8665

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

9. Birthplace (State or Foreign Country)

LITHUANIA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3737 CLARKS LANE APT. 107

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

REBBITZEN

16b. Kind of Business/Industry

RELIGION

17. Father's Name (First, Middle, Last)

JOSEPH

JACOB

MARCUS

18. Mother's Name (First, Middle, Maiden Surname)

ALTA

SPINKMAN

19a. Informant's Name/Relationship (Type, Print)

RABBI SIDNEY SHOHAM / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5703 MELLING AVE. MONTREAL, QUEBEC, CANADA H4W2C5 44W2C5

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BNAI ISRAEL

Date

2/28/97

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 Reisterstown Road Pikesville, MD 21208

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dementia

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DEBRA S WERTHEIMER MD 2434 W. Belvedere Ave, Balt, MD 21215

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

Julia Davidson-Rendell

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06304

Reg. No.

|  |   |  |   |  |   |  |  |  |
|--|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>LILLIAN ROSENGARTEN SCHERR  |  |   |  | 2. Date of Death<br>Month Day Year<br>FEBRUARY 25, 1997   |  | 3. Time of Death<br>0110   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>HEARTLAND HEALTH CARE CENTER  |  |   |  | 4b. City, Town, or Location of Death<br>ADELPHI   |  | 4c. County of Death<br>PRINCE GEORGES  |  |
| Funeral<br>Director  | 5. Social Security Number<br>217-42-3593  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>90 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>11/25/1906                                    |  |
|  | 9. Birthplace (State or Foreign Country)<br>NEW YORK  |  | 10a. State<br>MD  |  | 10b. County<br>MONTGOMERY   |  | 10c. City, Town or Location<br>TAKOMA PARK   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br>8510 FLOWER AVENUE # 12-B   |  | 10f. Zip Code<br>20912  |  | 10g. Citizen of What Country?<br>U.S.A.  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>SALESWOMAN                               |  | 16b. Kind of Business/Industry<br>DEPARTMENT STORE  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>SAMUEL ROSENGARTEN   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>SARAH (UNOBTAINABLE)   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>EDMUND F. SCHERR / SON  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11111 LAMPLIGHTER LANE POTOMAC, MD 20854   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>KING DAVID MEM. GARDENS   |  | Date<br>2/26/97   |  | 20c. Location - City or Town, State<br>FALLS CHURCH, VA                              |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br>IVES-PEARSON FUNERAL HOMES<br>472 N. WASHINGTON ST FALLS CHURCH, VA 22046   |  |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>immediate Cause (Final disease or condition resulting in death)<br>a. ACUTE PNEUMONIA<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |   |  |  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |   |  |   |  |  |  |
| Physician<br>/Medical<br>Examiner  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |  |   |  |  |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |   |  |  |  |
|  | 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br>D06674   |  | 29d. Date signed (Month, Day, Year)<br>FEBRUARY 25, 1997                             |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>MYRON L. LENKIN, md 2309 SHOREFIELD RD WHEATON, MD 20902  |  |   |  |   |  |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br>MAR 04 1997  |  |   |  | 32. Registrar's Signature<br>  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



*[Faint, illegible handwritten text]*

1991-10-10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06305

## Certificate of Death

Reg. No.

|  |  |  |  |   |   |   |  |  |
|--|--|--|--|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MILDRED SINGLETON</b>   |  |  |   | 2. Date of Death<br>Month <b>MAR</b> Day <b>2</b> Year <b>97</b>  |   | 3. Time of Death<br><b>1425 PM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Deaton Convalescence Center</b>   |  |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |   | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-20-6704</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 27, 1916</b>  | 9. Birthplace (State or Foreign Country)<br><b>Va.</b> |
|  | Usual Residence of Decedent  |  |  |   | 10e. State<br><b>Md.</b>  |   | 10b. County<br><b>N/A</b>  |  |
| To Be Completed by Funeral Director  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 10e. Street and Number<br><b>2008 McCulloh Street</b>  |  |
|  | 10f. Zip Code<br><b>21217</b>  |  |  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                   |  |
|  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th Grade</b> College (1-4 or 5+)  |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housekeeper</b>   |   | 16b. Kind of Business/Industry<br><b>Domestic</b>  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Willie Jones</b>   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lottie Jones</b>  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Elizabeth Cooper</b> <b>niece</b>   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1628 Ralworth Rd. Baltimore, Md. 21218</b>  |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):   |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arbutus Memorial Park</b>  |   | 20c. Location - City or Town, State<br><b>March 7 Baltimore County, Md.</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |  |   | 22. Name and Address of Facility<br><b>Nutter Funeral Homes, Inc.<br/>2501 Gwynns Falls PKWY Baltimore, Md. 21216</b>   |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Sepsis</b><br>Due to (or as a consequence of):<br><b>Infected Below the Knee Amputation stump</b><br>Due to (or as a consequence of):<br><b>Peripheral Vascular Disease</b><br>Due to (or as a consequence of):<br><b>Diabetes Mellitus</b> |  |  |   | Approximate Interval Between Onset and Death<br><b>2 days</b><br><b>6 weeks</b><br><b>10 years</b><br><b>20 years</b>   |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |  |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
|  |  |  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No           |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>   |  |  |
|  |  |  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred   |  |  |
|  |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. Signature and title of certifier<br>MD   |   | 29c. License number<br><b>D38675</b>  |  |  |
|  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>3/3/97</b>  |   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>SOEL MESHULAM 1147 S HANOVER ST BALTIMORE MD 21230</b> |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>  |  |  |  | 32. Registrar's Signature<br>   |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

9



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06306

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Esther Thompson

2. Date of Death

March

Day

3

Year

1997

3. Time of Death

5:20 AM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Geriatric Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

531-03-1363

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

05-09-1905

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State  
MD10b. County  
NA10c. City, Town or Location  
Baltimore

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

5505 Hopkins Bayview Circle

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Samuel Winslow Raymond

18. Mother's Name (First, Middle, Maiden Surname)

Mabel Babson

19a. Informant's Name/Relationship (Type, Print)

Robert W. Cottingham

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

211 Kemble Rd., Baltimore, MD 21218

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory 3-4-97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

James R. Kelm

22. Name and Address of Facility

Henry W. Jenkins & Sons  
4905 York Rd., Baltimore, MD 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CARDIAC ARRHYTHMIA

Approximate interval between Onset and Death

IMMEDIATE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):  
f. CORONARY ARTERY DISEASE

15 YEARS

Due to (or as a consequence of):  
g. CONGESTIVE HEART FAILURE

15 YEARS

Due to (or as a consequence of):  
h.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

29c. License number

D37089

29d. Date signed (Month, Day, Year)

3 3 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRUCE LEFF JOHNS HOPKINS GERIATRIC CTR BALTIMORE MD 21224

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

J. E. Thompson

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

100 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

(H)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06307

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALBERT

LEE

TATE

JR

2. Date of Death

Month

Day

Year

FEBRUARY 28, 1997

3. Time of Death

1610

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

2614 WOODBROOK AVENUE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

216 32 0463

6. Sex

M 2 F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

9/25/33

9. Birthplace (State or Foreign Country)

VA.

Usual Residence of Decedent

10a. State

MD.

10b. County

BALTIMORE CITY

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

Yes 2 No

10e. Street and Number

2614 WOODBROOK AVE.

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: AFRO AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BARBER

16b. Kind of Business/Industry

SELF EMPLOYED

17. Father's Name (First, Middle, Last)

ALBERT LEE TATE SR.

18. Mother's Name (First, Middle, Maiden Surname)

BEULAH WILLIS

19a. Informant's Name/Relationship (Type, Print)

HENRIETTA TATE WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2614 WOODBROOK AVE, BALTO. MD. 21217

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY 3/4/97

Date

20c. Location - City or Town, State

CATONSVILLE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME P.A.

1300 EUTAW PL. BALTO. MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

INSPECTION

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

MARCH 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

J. Laron Locke

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be prepared for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06308

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|   |  |   |  |  |  |   |   |  |  |
|---|--|---|--|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>ELIZABETH</b>  |  |   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>3</b> Year <b>1997</b>   |  |   |   | 3. Time of Death<br><b>3:14AM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>NORTH ARUNDEL Hospital Assn</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>   |  |   |   | 4c. County of Death<br><b>ANNE ARUNDEL</b>   |  |
| 5. Social Security Number<br><b>213 36 4906</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept 3 1938</b> |   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |
| Usual Residence of Decedent   |  |   |  |  |  |   |   |  |  |
| 10a. State<br><b>Md</b>   |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Crownsville</b>  |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>1070 Overcrest Drive</b>   |  |   |  | 10f. Zip Code<br><b>21032</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>               |   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>  |  |   | 16b. Kind of Business/Industry<br><b>Household</b>                      |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Alexander Syzmanski</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jennie Woczneicz</b>   |  |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Jerome E. Tolodziecki</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1070 Overcrest Dr., Crownsville, Md 21032</b>  |  |   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Our Lady of the fields</b>  |  |   | 20c. Location - City or Town, State<br><b>Millersville Md</b>           |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Hardesty Funeral Home P.A.<br/>12 Ridgely Ave., Annapolis, Md 21401</b>   |  |   |   |  |  |

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |                                       |  |  |
|---|--|---|---------------------------------------|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CARCINOMA OF HYPOPHARYNX WITH CERVICAL METAST.</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |  |   |                                       | Approximate Interval Between Onset and Death<br><b>4 yrs.</b>  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                       |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                       | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |                                       | 28b. Time of Injury<br><b>M</b>  |  |
|   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                       | 28d. Describe how injury occurred  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)      |                                       | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |                                       |  |  |
| 29b. Signature and title of certifier<br>   |  |   | 29c. License number<br><b>MD09711</b> |  | 29d. Date signed (Month, Day, Year)<br><b>3/3/97</b> |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Barry Ominsky, MD. 1600 CRAN HURRY S.W. GLEN BURNIE, MD 21061</b>  |  |   |                                       |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>   |  |   | 32. Registrar's Signature<br>         |  |  |

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



AL

NOV 10 1931

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06309

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN

ANN

UPDEGRAFF

2. Date of Death

Month Day Year  
MARCH 2, 1997

3. Time of Death

9:25 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SAINT JOWEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON, MARYLAND

4c. County of Death

BALTIMORE

5. Social Security Number

213-14-5482

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
August 16, 1902

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2106 Townhill Road

10f. Zip Code

21234

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

5

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William A. Biggs

18. Mother's Name (First, Middle, Maiden Surname)

Daisy Blades

19a. Informant's Name/Relationship (Type, Print)

Mr. Robert Ashley / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2106 Townhill Road Baltimore, Md. 21234

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Hilltop Service Corp.

Date

3/4/97

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee Mark T. Zavovna

Mark T. Zavovna

22. Name and Address of Facility

Leonard J. Ruck, Inc.

5305 Harford Road Baltimore, Md. 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ASPIRATION PNEUMONIA

IMMEDIATE

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

X Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Joginder P. Mehta, M.D.

29c. License number

D41410

29d. Date signed (Month, Day, Year)

March 03, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOGINDER P. MEHTA, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

Joginder P. Mehta, M.D.

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After the certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
document.

Medical Certification: To Be Completed by Physician/Medical Examiner

9

MAR 10 1961



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06310

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CATHERINE M. WOOTTON

2. Date of Death

MARCH 1, 1997

3. Time of Death

4:25 PM

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL ASSN

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

214-24-8283

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
NOV 18, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

925 Andrews Road

10f. Zip Code

21060

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Sales Associate

16b. Kind of Business/Industry

Dept. Store/  
Jewelry Dept.

17. Father's Name (First, Middle, Last)

Joseph Murdock

18. Mother's Name (First, Middle, Maiden Surname)

Estelle Shellhouse

19a. Informant's Name/Relationship (Type, Print)

Donald A. Wootton/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

925 Andrews Rd. Glen Burnie, MD 21060

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory, Inc. 3/3/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.  
299 Frederick Rd. Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. CONGESTIVE HEART FAILURE

YEARS

Due to (or as a consequence of):

b. ATHEROSCLEROTIC CORONARY ARTERY DISEASE

YEARS

Due to (or as a consequence of):

c. TOBACCO USE - DIABETES MELLITUS HYPERTENSION DISLIPIDEMIA

YEARS

Due to (or as a consequence of):

d. ACUTE RENAL FAILURE

WEEKS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MULTIPLE CORONAVASCULAR ACCIDENTS

CELLULITIS LOWER EXTREMITIES

ARTERIAL INSUFFICIENCY LOWER EXTREMITIES

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M.D.

29c. License number

D19991

29d. Date signed (Month, Day, Year)

3/1/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mrs. Rose M.D. Suite 500 200 Westmore Drive Glen Burnie Maryland 21061

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

A. Spideman

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

9

1957

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06311

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES WILSON

2. Date of Death

Month Day Year  
FEBRUARY 26 1997

3. Time of Death

1:35 AM

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE CITY

Funeral  
Director

5. Social Security Number

216-72-2542

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

39

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
DEC 29, 1957

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Lansdowne

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

335 Bigley Avenue

10f. Zip Code

21227

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Roll Tender

16b. Kind of Business/Industry

Printing Company

17. Father's Name (First, Middle, Last)

James Paul Wilson

18. Mother's Name (First, Middle, Maiden Surname)

Harriett Singleton

19a. Informant's Name/Relationship (Type, Print)

Regina Heath/sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

335 Bigley Ave. Lansdowne, MD 21227

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory, Inc. 2/26/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.  
299 Frederick Rd. Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 WEEK

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. SMALL CELL CARCINOMA OF THE LUNG

Due to (or as a consequence of):

4 MONTHS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD

29c. License number

AS 2441614-66

29d. Date signed (Month, Day, Year)

FEBRUARY 26, 1997

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

SAJID SHARIF HARBOR HOSPITAL CENTER BALTIMORE

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

S. J. Sharif

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

State  
Registrar



Секрет

№ 10 А 0 522

Items: 23 part I, 27, 28a, b, c, d, e, f per MEO G-745 3/11/97 reb  
Certificate of Death

Reg. No.

|   |  |   |  |   |   |  |   |  |
|---|--|---|--|---|---|--|---|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><b>TIMOTHY PATRICK WRIGHT</b>                            |   |  |   | 2. Date of Death<br>Month <b>MARCH</b> Day <b>01</b> Year <b>1997</b> |  | 3. Time of Death<br><b>2:01 PM</b>                        |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>121 S. CALHOUN ST 2nd floor</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>              |  | 4c. County of Death<br><b>N/A</b>                         |  |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>093-44-3534</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>43</b> Yrs.                      |  | 8. Date of Birth (Month, Day, Year)<br><b>MAR 1, 1954</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>New York</b>  |   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>           |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>121 South Calhoun Street</b>   |  | 10f. Zip Code<br><b>21223</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  | 15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>   |  | 15b. Kind of Business/Industry<br><b>Construction</b>   |   | 16. Decedent's Usual Residence (Specify only highest grade completed)<br>College (1-4 or 5+)   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Michael Thomas Wright</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rita Leahy</b>  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Michael Wright/brother</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2835 N. Clearbrook Cir. Delray Beach, FL 33445</b>  |   |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc. 3/3/97</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>   |   | 21. Signature of Funeral Service Licensee<br><br><b>George E. MacNabb</b>                                      |   |  |
| 22. Name and Address of Facility<br><b>Cremation Society of Maryland, Inc.<br/>299 Frederick Rd. Baltimore, MD 21228</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death)</b><br><br><b>NARCOTIC AND ALCOHOL INTOXICATION</b><br><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day, Year)<br><b>3/1/97</b>  |   |  |
| 28b. Time of Injury<br><b>unknown</b> M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred<br><b>Unknown</b>   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>121 S. Calhoun St. Baltimore, Md.</b>  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Found at home</b>  |  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |  |   |  |
| 29b. Signature and title of certifier<br><br><b>J. L. Aaron</b>  |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 02, 1997</b>  |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. L. Aaron, MD 111 Penn Street, Baltimore, Maryland 21201</b>  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>   |  | 32. Registrar's Signature<br><br><b>Julia Davidson-Randall</b>   |  |   |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that a death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be submitted for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06313

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELIZABETH, MINNIE WOLFORD

2. Date of Death

MARCH 2 1997

3. Time of Death

0405a

4a. Facility Name (If not institution, give street and number)

DEATON NURSING HOME

4b. City, Town, or Location of Death

BALTIMORE, MD

4c. County of Death

n/a

Funeral  
Director

5. Social Security Number

212-24-8899

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

FEB. 28, 1923

9. Birthplace (State or Foreign Country)

BALTIMORE, MD

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5107 CHALGROVE AVENUE

10f. Zip Code

21215

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

nursing sch.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NURSE;S ASSISTANT

16b. Kind of Business/Industry

LEVINDALE N.H.

17. Father's Name (First, Middle, Last)

Richard Stewart

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Greene

19a. Informant's Name/Relationship (Type, Print)

DIANE STATON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5107 CHALGROVE AVE., BALTIMORE, MD 15

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WOODLAWN CEMETERY

Date

3-7-97

20c. Location - City or Town, State

BALTIMORE Co., MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WM.C. MARCH FH.-1101 E. NORTH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

SEPSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

b.

PNEUMONIA

Due to (or as a consequence of):

2 weeks

c.

DECUBITUS ULCER

Due to (or as a consequence of):

2 Months

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MULTI INFARCT DEMENTIA

INSULIN DEPENDENT DIABETES MELLITUS

MULTI-INFARCT DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James P. G. Flynn MD

29c. License number

D01346

29d. Date signed (Month, Day, Year)

March 2 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES P. G. FLYNN MD DEATON SPECIALTY HOSPITAL 611 S. CHARLES 21230

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

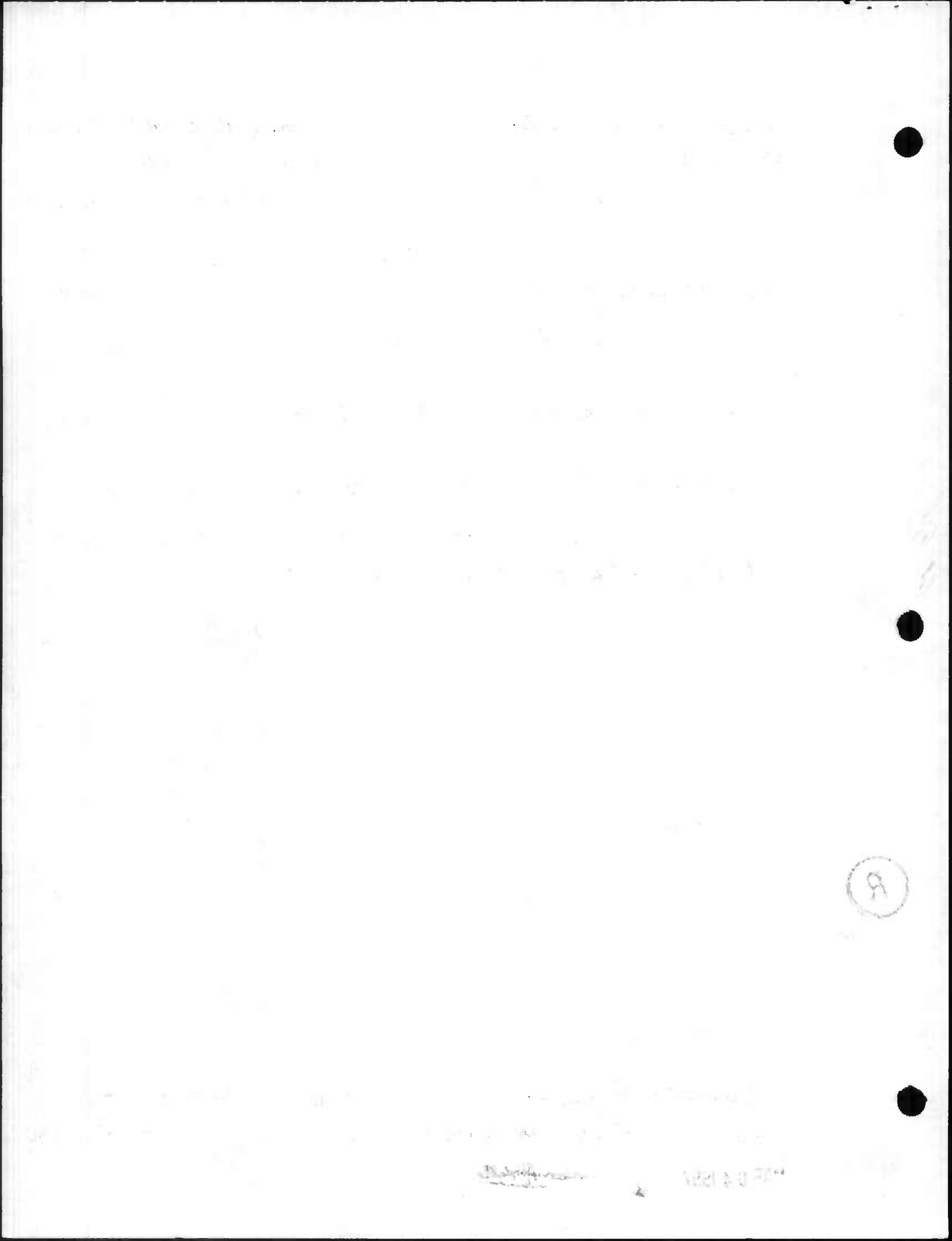
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06314

## Certificate of Death

Reg. No.

|  |   |   |   |                                       |  |  |   |   |
|--|---|---|---|---------------------------------------|--|--|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Katherine Gerstmyer Willett</b>  |   |   |                                       | 2. Date of Death<br>Month Day Year<br><b>March 3, 1997</b>   |  | 3. Time of Death<br><b>3:10 am</b>                                      |   |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>Edenwald</b>   |   |   |                                       | 4b. City, Town, or Location of Death<br><b>Towson</b>  |  | 4c. County of Death<br><b>Baltimore</b>                                 |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-05-5169</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.  | If Under 1 Year<br>Months Days        | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Feb 21, 1910</b>                                     |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |
|  | Usual Residence of Decedent   |   |   |                                       |  |  |   |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Baltimore</b>   | 10c. City, Town or Location<br><b>Towson</b>  |                                       |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   |
|  | 10e. Street and Number<br><b>800 Southerly Road</b>   |   |   |                                       | 10f. Zip Code<br><b>21286</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                       | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>n/a</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cashier</b>                       |                                       | 16b. Kind of Business/Industry<br><b>Baltimore County Tax Department</b>   |  |   |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Elmer Gerstmyer</b>   |   |   |                                       | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ada Larkin</b>   |  |   |   |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Thomas E. Willett/Son</b>  |   |   |                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3580 S. Ocean Shore Blvd., Flagler Beach, FL 32136</b>                                   |  |   |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Mem. Grdns.</b>                                       |                                       | 20c. Location - City or Town, State<br><b>3/5/97 Timonium, Maryland</b>  |  |   |   |
|  | 21. Signature of Funeral Service Licensee<br><b>Bryan W. Clary</b>  |   |   |                                       | 22. Name and Address of Facility<br><b>Lemmon Funeral Home<br/>10 W. Padonia Road, Timonium, MD 21093</b>  |  |   |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>metastatic cancer of colon</b><br>Due to (or as a consequence of):<br><b>congestive heart failure</b><br>Due to (or as a consequence of):<br><b>atherosclerotic disease</b><br>Due to (or as a consequence of):<br><b>multiple strokes</b>  |   |   |                                       |  |  |   | Approximate Interval Between Onset and Death<br><b>1 yr.</b><br><b>2 yrs.</b><br><b>10 yrs.</b><br><b>2 yr.</b> |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>23b. Did tobacco use contribute to the cause of death?</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown<br><br><b>24a. Was an autopsy performed?</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>24b. Were autopsy findings available prior to completion of cause of death?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |   |                                       |  |  |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                                       |  |  |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>       |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   | 28d. Describe how injury occurred   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><b>physician</b>   |   | 29c. License number<br><b>D 29767</b> |  | 29d. Date signed (Month, Day, Year)<br><b>March 3, 1997</b>                                    |   |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Marcelino D. Albuerni, M.D. 800 Southerly Road, Towson, MD 21286</b>  |   |   |   |                                       |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>  |   |   |   |                                       |  |  |   |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: The death certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06315

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Paul C. WALTMAN II

2. Date of Death

Feb. 28 1997 10:02 pm

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

212-60-0700

6. Sex

M 2 F

7. Age (In yrs. last birthday)

46

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

May 8, 1950

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

332 Riverside Drive

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
 If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

mechanic

16b. Kind of Business/Industry

Tate Access Floors

17. Father's Name (First, Middle, Last)

Paul C. Waltman

18. Mother's Name (First, Middle, Maiden Surname)

Dolores E. Hardy

19a. Informant's Name/Relationship (Type, Print)

Paul C. Waltman/Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

332 Riverside Drive Pasadena Md. 21122

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc.

Date

MARCH

20c. Location - City or Town, State

Catonsville, Md.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

McCully Funeral Home of Pasadena  
3204 Mountain Road Pasadena, Md. 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Hemorrhagic shock

Immediate

Due to (or as a consequence of):

b. Upper gastrointestinal bleeding

1 day

Due to (or as a consequence of):

c. Esophageal Varices

1 year

Due to (or as a consequence of):

d. Alcoholic Cirrhosis

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient

☒ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

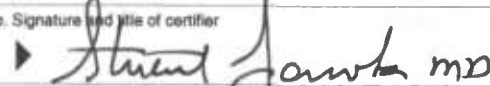
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D22483

29d. Date signed (Month, Day, Year)

Feb. 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STUART JACOBS MD North Arundel Hospital Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature


State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

97 06316

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
|---|--|--|---|--|--|--|--|--|---|----|-----------------------|-------|----|-----------------------------|-------|----|--|-------|----|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Gordon Z. Warehime   |  |   |  | 2. Date of Death<br>Month: 2, Day: 25, Year: 97  |  | 3. Time of Death<br>3:50 PM  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Carroll County General Hospital  |  |   |  | 4b. City, Town, or Location of Death<br>Westminster  |  | 4c. County of Death<br>Carroll   |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
| Funeral<br>Director   | 5. Social Security Number<br>218-10-8632   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>85 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Nov. 12, 1911   |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
|   | Usual Residence of Decedent  |  | 9. Birthplace (State or Foreign Country)<br>Lineboro, MD  |  | 10. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
| To Be Completed by Funeral Director   | 10a. State<br>MD   |  | 10b. County<br>Carroll  |  | 10c. City, Town or Location<br>Lineboro  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
|   | 10e. Street and Number<br>5317 N. Mill Street  |  |   |  | 10f. Zip Code<br>21088   |  | 10g. Citizen of What Country?<br>USA   |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Welder                               |  | 16b. Kind of Business/Industry<br>Auto. Body Repair  |  |  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
|   | 17. Father's Name (First, Middle, Last)<br>Denton M. Warehime  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Catharine Monath   |  |  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Ruth A. Wentz/Daughter   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>R.R.#2 Box 2862 Spring Grove, PA 17362  |  |  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Lineboro Cemetery   |  | Date<br>March 1, 1997  |  | 20c. Location - City or Town, State<br>Lineboro, Maryland                                      |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br>Geiple Funeral Home, Inc.<br>53 Main St. Glen Rock, PA 17327  |  |  |  |  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
|   | <table border="1"> <tr> <td rowspan="4">           immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>ACUTE PULMONARY EDEMA</td> <td>HOURS</td> </tr> <tr> <td>b.</td> <td>ACUTE MYOCARDIAL INFARCTION</td> <td>HOURS</td> </tr> <tr> <td>c.</td> <td>ATHEROSCLEROTIC CORONARY HEART DISEASE</td> <td>YEARS</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> |  |   |  |  |  |  |  | immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | ACUTE PULMONARY EDEMA | HOURS | b. | ACUTE MYOCARDIAL INFARCTION | HOURS | c. | ATHEROSCLEROTIC CORONARY HEART DISEASE | YEARS | d. |  |
| immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a.   | ACUTE PULMONARY EDEMA                  | HOURS   |  |  |  |  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
|   | b.   | ACUTE MYOCARDIAL INFARCTION            | HOURS   |  |  |  |  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
|   | c.   | ATHEROSCLEROTIC CORONARY HEART DISEASE | YEARS   |  |  |  |  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
|   | d.   |  |   |  |  |  |  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>NON INSULIN DEPENDENT DIABETES MELLITUS   |  |  |   |  |  |  |  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |   |  |  |  |  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |  |  |  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |  |  |  |  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |  |  |  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |   |  |  |  |  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |  |   |  |  |  |  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
| 28a. Date of Injury (Month, Day, Year)<br>28b. Time of Injury<br>28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |  |  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |  |  |  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
| 29b. Signature and title of certifier<br>MD   |  |  |   |  |  |  |  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
| 29c. License number<br>DO1663   |  |  |   |  |  |  |  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
| 29d. Date signed (Month, Day, Year)<br>2/25/97  |  |  |   |  |  |  |  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>VINCENT J. FIOCCO JR.<br>8 ANCHOR ST<br>WESTMINSTER MD 21157  |  |  |   |  |  |  |  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |
| 31. Date filed (Month, Day, Year)<br>MAR 04 1997<br>32. Registrar's Signature<br>   |  |  |   |  |  |  |  |  |   |    |                       |       |    |                             |       |    |  |       |    |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06317

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Frederick Williams</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>Feb. 28 1997</b>  |  | 3. Time of Death<br><b>6:10 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>VA MHCS FORT HOWARD DIVISION</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Fort Howard</b>   |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>218-07-4789</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>03-23-19</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  | 10e. Street and Number<br><b>1306 Riggs Avenue</b>   |  | 10f. Zip Code<br><b>21217</b>  |  |
|   | 10g. Citizen of What Country?<br><b>USA</b>   |  |   |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1943-46</b> |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Black</b>   |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th</b> College (1-4or 5+) <b>N/A</b>                          |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>   |  |   |  | 16b. Kind of Business/Industry<br><b>Freight Loading</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Charles Williams</b>   |  |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Barnes Williams</b>  |  |   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Clifton Lyons</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1136 N. Gilmer Street - Baltimore, MD 21217</b>              |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest</b>   |  | 20c. Location - City or Town, State<br><b>3-5-97 Owings Mills, MD</b>  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Albert P. Wyllie Funeral Home P.A.</b><br><b>1638 N. Gilmer Street Baltimore, MD 21217</b>  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Squamous Lung Cancer with Metastasis to Brain/Spine</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  | Approximate Interval Between Onset and Death<br><b>8 months</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Malnutrition</b>   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D30528</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>Feb 28th 1997</b>  |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Bala Duggirala, MD 9600 North Point Road Fort Howard, MD 21052</b>   |  |   |  | 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>  |  |  |  |
|   | 32. Registrar's Signature<br>   |  |   |  |  |  |  |  |



AL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06318

Reg. No.

|   |   |   |  |  |  |  |  |  |
|---|---|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Jacob Melvin Wickman</b>                   |   |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>2</b> Year <b>1997</b> |  | 3. Time of Death<br><b>12:15 p.m.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Genesis Hamilton</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>        |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-05-0380</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                                       | 8. Date of Birth (Month, Day, Year)<br><b>April 28, 1912</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|   | Usual Residence of Decedent   |   |  |  |  |  |  |  |
| 10a. State<br><b>Md.</b>  |   | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Perry Hall</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>9446 Bellhall Drive</b>  |   |   |  | 10f. Zip Code<br><b>21236</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b>Supervisor</b>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  |  | 16b. Kind of Business/Industry<br><b>Social Security U.S. Gov't.</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Jacob Wickman</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillian Hamilton</b>   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Donna C. Groome (Daughter)</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9446 Bellhall Drive Perry Hall, Md. 21236</b>  |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>  |  | Date<br><b>3/5/97</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore Maryland</b>   |  |  |
| 21. Signature of Funeral Service Licensee <b>Milton J Knight Jr</b><br><i>Milton J Knight Jr</i>  |   |   |  | 22. Name and Address of Facility<br><b>Leonard J. Ruck, Inc.</b><br><b>5305 Harford Road Baltimore, Maryland 21214</b>   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br><b>a. sepsis</b><br>Due to (or as a consequence of):<br><b>b. gangrene of Right lower extremity</b><br>Due to (or as a consequence of):<br><b>c. ischemia of Right lower Extremity</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>1 day several weeks</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|   |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   | 29b. Signature and title of certifier<br><i>Jeffrey Cool</i>  |  |  |  |  |  |  |
|   |   | 29c. License number<br><b>D34650</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/3/97</b>   |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>5601 Loch Raven Blvd, Baltimore, MD 21239, Dr. Jeffrey Cool</b>  |   |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>   |   | 32. Registrar's Signature<br><i>John Anderson</i>   |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Coroner: The law requires that the death certificate be executed within 24 hours after death.

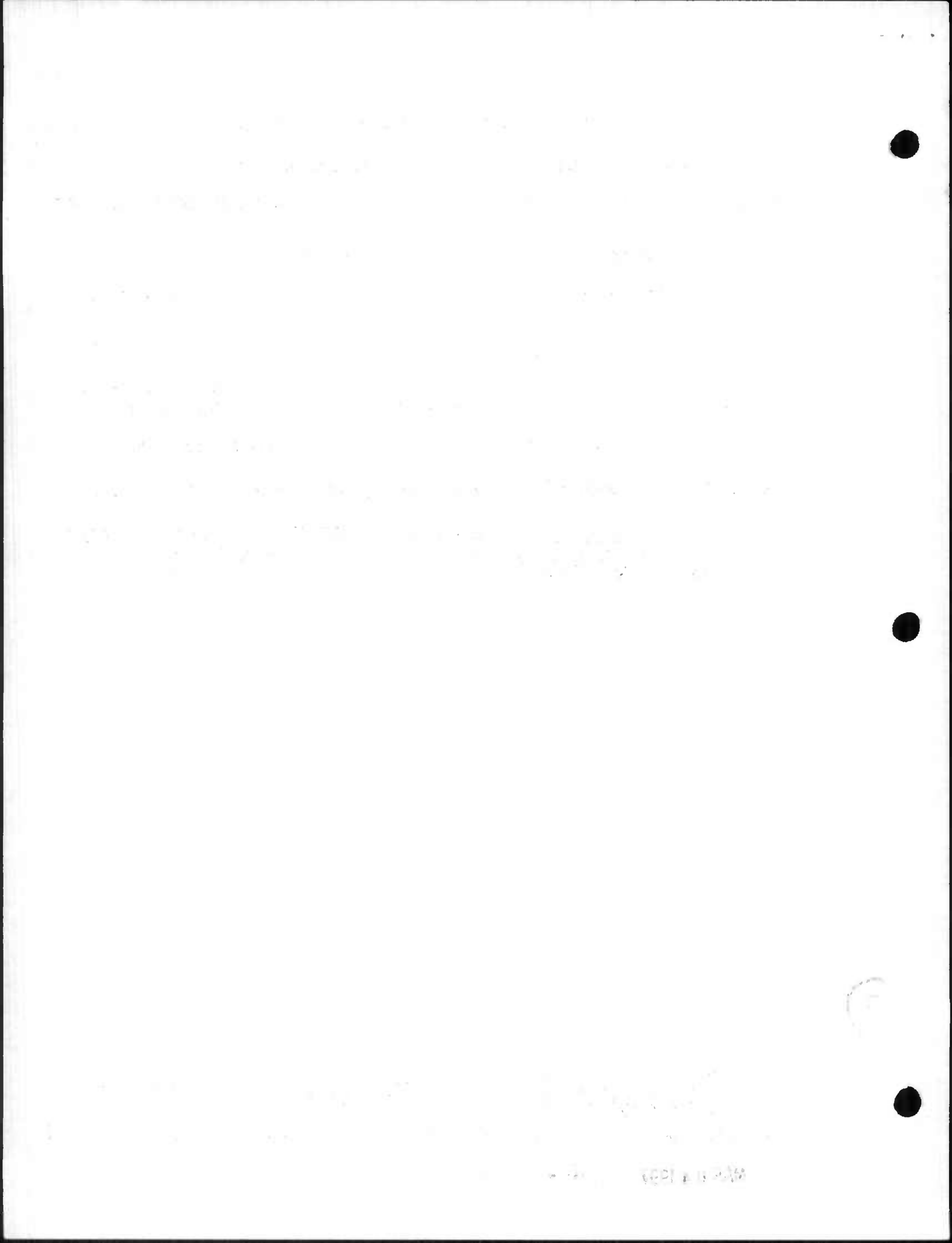
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06319

Item 11 Per FH Film G751 9-10-97 rja

## Certificate of Death

Reg. No.

|   |  |  |  |                                |  |
|---|--|--|--|--------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JEAN E. WARREN</b>  |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>24</b> Year <b>1997</b>   |                                | 3. Time of Death<br><b>0310</b>  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>Gilchrist Center</b>  |  | 4b. City, Town, or Location of Death<br><b>TOWSON</b>  |                                | 4c. County of Death<br><b>BALTIMORE</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-38-2754</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>05/06/1940</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |                                |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |  | 10e. State<br><b>MD</b>  |                                | 10b. County<br><b>N/A</b>  |
|   | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |                                |  |
|   | 10e. Street and Number<br><b>3043 Belmont Avenue</b>   |  | 10f. Zip Code<br><b>21216</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>4</b>            |                                | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Office Assistant III</b>  |
|   | 16b. Kind of Business/Industry<br><b>Recreation &amp; Parks</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Nevard Cooper</b>  |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Mae Cooper</b>  |
|   | 19e. Informant's Name/Relationship (Type, Print)<br><b>Tangee Warren</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7200 Oak Haven Circle, Baltimore, MD 21244</b> |                                |  |
|   | 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King Memorial Park</b>  |                                | 20c. Location - City or Town, State<br><b>2/27 Randallstown, md</b>  |
|   | 21. Signature of Funeral Service Licensee<br><b>Leroy O. Dyett</b>   |  | 22. Name and Address of Facility<br><b>LEREOY O. DYETT &amp; SON FUNERAL HOME, P.A.<br/>4600 LIBERTY HEIGHTS AVE., BALTO. 21207</b>                |                                |  |
|   | 23e. Part I. Enter the disease, and complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. metastatic Lung Cancer</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death<br><b>6 months</b>  |                                |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |                                |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |                                |  |
| 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |                                |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |                                |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |                                |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>  |  |  |  |                                |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |  |  |                                |  |
| 28a. Date of Injury (Month, Day, Year)  |  |  |  |                                |  |
| 28b. Time of Injury<br>M  |  |  |  |                                |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |                                |  |
| 28d. Describe how injury occurred   |  |  |  |                                |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |                                |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |                                |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |                                |  |
| 29b. Signature and title of certifier<br><b>Anthony Riley, MD</b>   |  |  |  |                                |  |
| 29c. License number<br><b>D25205</b>  |  |  |  |                                |  |
| 29d. Date signed (Month, Day, Year)<br><b>February 24, 1997</b>   |  |  |  |                                |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>W. A. R. Riley G BMC 6701 N. Charles St. Balto. MD 21204</b>   |  |  |  |                                |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 04 1997</b>   |  |  |  |                                |  |
| 32. Registrar's Signature<br><b>John Davidson</b>   |  |  |  |                                |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06320

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rose Weilbrenner

2. Date of Death

Month

Day

Year

02

26

97

3. Time of Death

6:30 AM

4a. Facility Name (If not institution, give street and number)

Multi-medical 7700 York Rd Balt. MD.

4b. City, Town, or Location of Death

Balt. MD.

4c. County of Death

Balt.

Funeral  
Director

5. Social Security Number

216-07-1349

6. Sex

1 ☐ M2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

DECEMBER 14, 1914

9. Birthplace (State or Foreign Country)

BALTIMORE, MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE CITY

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4610 MARY AVENUE

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOUSEKEEPING-OWN HOME

17. Father's Name (First, Middle, Last)

ANTONIO DONATELLI

18. Mother's Name (First, Middle, Maiden Surname)

ADELAIDE ROSSI

19a. Informant's Name/Relationship (Type, Print)

LAURA M. PLANTHOLT (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4610 MARY AVENUE BALTIMORE, MARYLAND 21206

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PARKWOOD CEMETERY MARCH 1, 1997

Date

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

LASSAHL FUNERAL HOME, INC.  
7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Uremia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. End-stage Renal Disease

Due to (or as a consequence of):

c. Diabetes Mellitus

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

days

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ADD: Hypertension, Stroke

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

N/A

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation8 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier

[Signature]

29c. License number

D17118

29d. Date signed (Month, Day, Year)

2/26/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Paul Schwartz MD 4000 Old Court Rd Suite 203 21208

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital, the attending physician, the funeral director, and the State Registrar. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Handwritten signature or initials.

WIR 0 9 1943

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06321

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCES

WESTERMAN

2. Date of Death  
Month Day Year  
FEBRUARY 25, 19973. Time of Death  
11:50PM

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON, MARYLAND

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

214-46-8321

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

AUGUST 8, 1912

9. Birthplace (State or Foreign Country)

BALTIMORE, MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE COUNTY

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8402 BELAIR ROAD

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BOOK KEEPER

16b. Kind of Business/Industry

G.M.A.C.

17. Father's Name (First, Middle, Last)

JOSEPH WEINERS

18. Mother's Name (First, Middle, Maiden Surname)

MARY ROTH

19a. Informant's Name/Relationship (Type, Print)

JOSEPH G. WESTERMAN (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8402 BELAIR ROAD BALTIMORE, MARYLAND 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. JOSEPH'S CHURCH CEM. MARCH 1, 1997

Date

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

LASSAHN FUNERAL HOME, INC.  
7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBRO- VASCULAR ACCIDENT

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE LUNG DISEASE

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 37254

29d. Date signed (Month, Day, Year)

2-26-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOON P. LIM, MD 7620 YORK ROAD TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

MAR 04 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar

MADE IN U.S.A.

MADE IN U.S.A.



97 06322

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>WILLIAM WAYNE WARNICK, SR.   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>FEB. 27 97  |  | 3. TIME OF DEATH<br>8:30 A M   |   |
| 4. SOCIAL SECURITY NUMBER<br>207-24-1827   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>62 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Oct. 8, 1934  |   |
| 8. FACILITY NAME (If not institution, give street and number)<br>1359 Brenda Road  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Severn   |  | 9c. COUNTY OF DEATH<br>Anne Arundel  |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |   |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Anne Arundel  |  | 10c. CITY, TOWN OR LOCATION<br>Severn   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |   |
| 10e. STREET AND NUMBER<br>1359 Brenda Road   |  |  |  | 10f. ZIP CODE<br>21144  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>Army/Vietnam   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) 12 College (1-4 or 5+) N/A  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Enlisted   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>U.S. Army   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Bill Warnick  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Hester unknown   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Wendy Cozzone  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>533 Donaldson Ave Severn, Md. 21144  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Md. Veterans Cemetery 3-3   |  | 20c. LOCATION — City or Town, State<br>Crownsville, Md.   |  | 20d. DATE<br>3-3   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles Bannix</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Hardesty Funeral Home P.A. 21054<br>851 Annapolis Rd. Gambrills. Md.  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. Ruptured posterior papillary muscle, left ventricle<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  | Approximate Interval Between Onset and Death<br>0 |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | b. Myocardial infarct, posterior septum and LVW<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  | 12 hrs  |
|  |  | c. Atherosclerotic coronary artery disease<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  | years   |
|  |  | d.   |  |   |  |  |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Marked pulmonary edema<br>Hemopericardium  |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>NA   |  | 28b. TIME OF INJURY<br>NA M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br>NA  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>NA  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>NA   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Ferdinand C. Rodriguez</i> M.D.  |  |  |  | 29c. LICENSE NUMBER<br>D-15028  |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/28/97   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Ferdinand C. Rodriguez, M.D.; 301 Hospital Dr., Glen Burnie, Md. 21061  |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>MAR 04 1997   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Davidson</i>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

JA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



(AL)

127 3 11 1941



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06323

Reg. No.

|  |  |   |   |   |   |  |  |  |
|--|--|---|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Hellen L. Yox                            |   |   |   | 2. Date of Death<br>Month Day Year<br>March 3, 1997 |  | 3. Time of Death<br>7:35 A.M.  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>11631 Central Ave. |   |   |   | 4b. City, Town, or Location of Death<br>Ridgely     |  | 4c. County of Death<br>Caroline  |  |
| Funeral<br>Director  | 5. Social Security Number<br>236-56-9637   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>58 Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                      | 8. Date of Birth (Month, Day, Year)<br>June 18, 1938   |  | 9. Birthplace (State or Foreign Country)<br>Kentucky   |
|  | Usual Residence of Decedent  |   |   |   |   |  |  |  |
| 10a. State<br>Maryland   |  | 10b. County<br>Anne Arundel   |   | 10c. City, Town or Location<br>Odenton  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br>552 Stoney Hill Court  |  |   |   | 10f. Zip Code<br>21113  |   | 10g. Citizen of What Country?<br>United States   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br>12  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Nurse  |   |  | 16b. Kind of Business/Industry<br>Health Care  |  |
| 17. Father's Name (First, Middle, Last)<br>Asa W. Thompson   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Flora D. Ratcleff  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Terry L. Gill / Daughter   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11631 Central Ave. Ridgely, MD 21660   |   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Pleasant Hill Cem.  |   | 20c. Location - City or Town, State<br>March 6, 1997 Reistertown, MD   |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br>Kirkley-Ruddick Funeral Home<br>421 Crain Hwy. S.E. Glen Burnie, MD 21061   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. Metastatic Colon Carcinoma<br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |   |   |   |  |  | Approximate Interval Between Onset and Death<br>5 1/4 yrs.   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
|  |  |   |   |   |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred  |
|  |  |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   | 29b. Signature and title of certifier<br>   |   | 29c. License number<br>D31551  |  | 29d. Date signed (Month, Day, Year)<br>March 4, 1997   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. Russell DeLuca 1600 Crain Hwy. Glen Burnie, MD 21061 Suite 602   |  |   |   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 04 1997   |  |   |   | 32. Registrar's Signature<br>   |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

8

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item 20a,c Per PHY Film G745 3-5-97 rja

State of Maryland / Department of Health and Mental Hygiene

97 06324

Item 24a,b,25,29a,d Per PHY Film G745 3-4-97 rja

Certificate of Death

Reg. No.

|   |   |  |  |  |  |  |   |   |  |  |
|---|---|--|--|--|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Thomas Joseph Zippler</b>  |  |  |  |  |  | 2. Date of Death<br>Month <b>2</b> Day <b>19</b> Year <b>97</b> |   | 3. Time of Death<br><b>6:00 pm</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>9 Tearose Drive</b>  |  |  |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>        |   | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-12-9545</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>1-30-1922</b>         |   | 9. Birthplace (State or Foreign Country)<br><b>P.A.</b>  |  |
|   | Usual Residence of Decedent   |  |  |  |  |  |   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>middlenriver</b>   |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>9 Tearose Drive</b>  |  |  |  | 10f. Zip Code<br><b>21220</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                  |   |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1943-1945</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Machine Oiler</b>  |  |   | 16b. Kind of Business/Industry<br><b>Sparrows Point</b>                 |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Joseph Zippler</b>  |  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ellen Unknown</b>  |   |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Thomas M. Zippler Son</b>  |  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9 Tearose Drive Balto. md. 21220</b> |   |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garden OF Faith</b> |  |  | 20c. Location - City or Town, State<br><b>ROSEDALE Md.</b>      |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>   |  |  |  |  | 22. Name and Address of Facility<br><b>Charles S. Zeiler &amp; Son, INC.<br/>6224 Eastern Avenue<br/>Baltimore, md. 21224</b>            |   |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. myocardial failure</b><br>Due to (or as a consequence of):<br><b>b. ischemic cardiomyopathy</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |  |  |   |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |  |  |  |   |   |  |  |
| 23c. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |  |  |   |   |  |  |
| 23d. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |  |  |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |  |  |   |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |  |  |  |  |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |  |  |  |  |  |   |   |  |  |
| 28a. Date of Injury (Month, Day Year) 28b. Time of Injury <b>M</b> 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |  |   |   |  |  |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |  |  |  |   |   |  |  |
| 29b. Signature and title of certifier <b>Rodney Brooks md</b> 29c. License number <b>043636</b> 29d. Date signed (Month, Day, Year) <b>3-4-97</b>   |   |  |  |  |  |  |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Rodney Brooks md 3411 Bank Street Balto. md 21224</b>  |   |  |  |  |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year) <b>MAR 04 1997</b> 32. Registrar's Signature <b>[Signature]</b>   |   |  |  |  |  |  |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23d show any injury or other traumatic event, the Medical Examiner must be notified at 5055.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06325

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCES

JEAN

ANTHONY

2. Date of Death

Month Day Year  
FEBRUARY 13, 1997

3. Time of Death

7:00 A.M.

4a. Facility Name (If not institution, give street and number)

216 DITTY COURT

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

217-30-3433

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
3-19-34

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

ANNE ARUNDEL CO.

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

216 DITTY COURT

10f. Zip Code

21060

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

NONE

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

TITLE EXAMINER

16b. Kind of Business/Industry

D.M.V.

17. Father's Name (First, Middle, Last)

FREDERICK GAUSE

18. Mother's Name (First, Middle, Maiden Surname)

KATHERINE ALLEN

19a. Informant's Name/Relationship (Type, Print) HUSBAND  
ROBERT GEORGE ANTHONY19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
216 DITTY COURT GLEN BURNIE MARYLAND 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

GLEN HAVEN MEMORIAL PK.

Date

2-17-97

20c. Location - City or Town, State

GLEN BURNIE MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME

1 SECOND AVENUE S.W. GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Hypertensive Heart Disease

Due to (or as a consequence of):

b. Hyperlipidemia

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

10-12 yrs.

6 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D40519

29d. Date signed (Month, Day, Year)

2.14.97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIRZA NUSAIREE, M.D., 7845 OAKWOOD ROAD, GLEN BURNIE, MARYLAND 21061

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06326

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Harry Carl Allendorfer, Jr.

2. Date of Death

Month Day Year  
Feb. 15, 1997

3. Time of Death

4:25 AM

4a. Facility Name (If not institution, give street and number)

Manor Care Potomac

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

159-14-0783

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 22, 1919

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

8807 Tallyho Trail

10f. Zip Code

20854

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
white15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Captain, U.S. Navy

16b. Kind of Business/Industry

U.S. Navy

17. Father's Name (First, Middle, Last)

Harry Carl Allendorfer, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Beaujon

19a. Informant's Name/Relationship (Type, Print)

Nancy Carroll Allendorfer/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8807 Tallyho Trail, Potomac, Md. 20854

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Arlington National Cem., Feb. 21, 97 Arlington, Va.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

2222 Wisconsin Ave., N.W., Wash., D.C. 20007

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. metastatic prostate cancer

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

years

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24e. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?  
☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
Work?  
☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D38781

29d. Date signed (Month, Day, Year)

February 17, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael Grady, M.D., 4910 Massachusetts Ave., N.W., Washington, D.C. #312

31. Date filed (Month, Day, Year)

FEB 19 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

30



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06327

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD KENNETH ARCH

2. Date of Death

Month Day Year  
FEBRUARY 14, 1997

3. Time of Death

7:08PM

4a. Facility Name (If not institution, give street and number)

11717 GREENLANE DRIVE

4b. City, Town, or Location of Death

POTOMAC

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

192-14-6857

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

08/03/1926

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

POTOMAC

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11717 GREENLANE DRIVE

10f. Zip Code

20854

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No WW II

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PHARMACIST

16b. Kind of Business/Industry

DRUG STORE

17. Father's Name (First, Middle, Last)

ABRAHAM ARCH

18. Mother's Name (First, Middle, Maiden Surname)

LENA YOFFE

19a. Informant's Name/Relationship (Type, Print)

ZELDA ARCH

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11717 GREENLANE DRIVE, POTOMAC, MARYLAND 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

JUDEAN MEMORIAL GARDENS 02/17

Date

20c. Location - City or Town, State

NORBECK, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.

1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

MYOCARDIAL INFARCTION

Due to (or as a consequence of):

CORONARY ARTERY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D43272

29d. Date signed (Month, Day, Year)

FEBRUARY 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUNITA HANJURA, MD 809 VIER'S MILL ROAD, ROCKVILLE, MARYLAND 20851

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06328

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VIOLET M. ADAMS

2. Date of Death

Feb 15, 1997

3. Time of Death

2:30 Am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Mariner Health Care Of Laurel

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George

5. Social Security Number

578-36-7298

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 22, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7620 Maple Avenue

10f. Zip Code

20912

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Day Care Provider

16b. Kind of Business/Industry

Child Care

17. Father's Name (First, Middle, Last)

Clifton Lancaster

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Powell

19a. Informant's Name/Relationship (Type, Print)

Patricia Smith (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16408 Edge Park Ct., Bowie, MD 20716

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Ash Memorial Cem.

Date

2/20

20c. Location - City or Town, State

Sandy Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.

ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cerebrovascular Accident

Approximate Interval Between Onset and Death

YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

DIABETES

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 24997

29d. Date signed (Month, Day, Year)

2/17/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LUIS A. CASAS MD

F317 CHERRY LANE

LAUREL MD. 20707

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

1907

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06329

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Puth Boone

2. Date of Death

Month

Day

Year

Feb

15

97

3. Time of Death

7:12P

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

216-05-3079

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug 26, 1907

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Crownsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

771 Barger Drive

10f. Zip Code

21032

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

Woodlawn Cemetery

17. Father's Name (First, Middle, Last)

Anderson F. Spicer

18. Mother's Name (First, Middle, Maiden Surname)

Mary Virginia Ruby

19a. Informant's Name/Relationship (Type, Print)

Estelle Youngbar, daughter 771 Barger Dr., Crownsville, MD 21032

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lorraine Park Cemetery

Date

Feb 19 1997

20c. Location - City or Town, State

Woodlawn, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home  
495 Gov Ritchie Hwy., Severna Park, MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Renal Failure

Due to (or as a consequence of):

b. Dehydration

Due to (or as a consequence of):

c. Hypoparathyroidism

Due to (or as a consequence of):

d. Hypocalcemia

Approximate Interval Between Onset and Death

1 wk

1 wk

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 8 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Pat Jett MD

29c. License number

50756

29d. Date signed (Month, Day, Year)

Feb 16 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jett 2448 Holly Ave #100 Annapolis MD 21401

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

[Signature]

State

Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06330

## Certificate of Death

Reg. No.

|   |   |  |   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
|---|---|--|---|--------------------------------|--|------------------|----------------------------------|----------|--------------------|----------------------------------|----------|----------|----------------------------------|--|---|--|----------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>RUTH BRENNEMAN</b>   |  | 2. Date of Death<br>Month <b>February</b> Day <b>11</b> Year <b>1997</b>  |                                | 3. Time of Death<br><b>7:20 am</b>   |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>   |                                | 4c. County of Death<br><b>Allegany</b>   |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-28-9620</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 7, 1931</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  | 10e. State<br><b>MD</b>   |                                | 10b. County<br><b>Garrett</b>  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
|   | 10c. City, Town or Location<br><b>Oakland</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
|   | 10e. Street and Number<br><b>2198 Shady Dell Rd.</b>  |  | 10f. Zip Code<br><b>21550</b>   |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>Housewife</b>      |                                | 16. Kind of Business/Industry<br><b>Home</b>   |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
|   | 17. Father's Name (First, Middle, Last)<br><b>Edgar ----- Upole</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Freda Mae Fulmer</b>  |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>James Brenneman/ Son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1990 Silver Knob Rd., Oakland, MD 21550</b>   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Pleasant Valley Cem.</b>   |                                | 20c. Location - City or Town, State<br><b>2/14/97 Oakland, Maryland</b>  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Stewart Funeral Home<br/>32 S. Second St., Oakland, MD 21550</b>   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
|   | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                             |  |   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
| <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Sepsis</b></td> <td>Due to (or as a consequence of):</td> <td>24 hours</td> </tr> <tr> <td>b. <b>Fungemia</b></td> <td>Due to (or as a consequence of):</td> <td>24 hours</td> </tr> <tr> <td>c. _____</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. <b>Fungal peritonitis from peritoneal dialysis</b></td> <td></td> <td>48 hours</td> </tr> </table> |   |  |   |                                | Immediate Cause (Final disease or condition resulting in death)  | a. <b>Sepsis</b> | Due to (or as a consequence of): | 24 hours | b. <b>Fungemia</b> | Due to (or as a consequence of): | 24 hours | c. _____ | Due to (or as a consequence of): |  | d. <b>Fungal peritonitis from peritoneal dialysis</b> |  | 48 hours |
| Immediate Cause (Final disease or condition resulting in death)   | a. <b>Sepsis</b>  | Due to (or as a consequence of):   | 24 hours  |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
|   | b. <b>Fungemia</b>  | Due to (or as a consequence of):   | 24 hours  |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
|   | c. _____  | Due to (or as a consequence of):   |   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
|   | d. <b>Fungal peritonitis from peritoneal dialysis</b>   |  | 48 hours  |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic renal failure needing dialysis, diabetes mellitus, hypoproteinemia</b>   |   |  |   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |  |   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
| 28a. Date of Injury (Month, Day Year)   |   |  |   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
| 28b. Time of Injury<br>M  |   |  |   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
| 28d. Describe how injury occurred   |   |  |   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |  |   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
| 29b. Signature and title of certifier<br>  |   |  |   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
| 29c. License number<br><b>D 19318</b>   |   |  |   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
| 29d. Date signed (Month, Day, Year)<br><b>February 11<sup>th</sup> 1997</b>   |   |  |   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Ranjithan, 517 Oldtown Road, Cumberland, MD 21502</b>  |   |  |   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
| 31. Date filed (Month, Day, Year)<br><b>FEB 18 1997</b>   |   |  |   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |
| 32. Registrar's Signature<br>  |   |  |   |                                |  |                  |                                  |          |                    |                                  |          |          |                                  |  |   |  |          |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06331

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARTHA

MAURINE

BROOKHART

2. Date of Death

Month FEBRUARY Day 18, Year 1997

3. Time of Death

11:10 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

119 W. PENNINGTON STREET

4b. City, Town, or Location of Death

OAKLAND

4c. County of Death

GARRETT

5. Social Security Number

215-36-9180

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) OCT 23, 1903

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

GARRETT

10c. City, Town or Location

OAKLAND

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

119 W. PENNINGTON STREET

10f. Zip Code

21550

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

RALPH

ENGLE

18. Mother's Name (First, Middle, Maiden Surname)

ETTA

VIOLA

LAYMAN

19a. Informant's Name/Relationship (Type, Print)

MAURICE S. BROOKHART - HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

119 W. PENNINGTON STREET OAKLAND, MD 21550

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

GARRETT MEMORIAL GARDENS

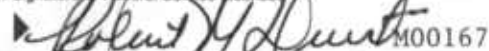
Date

2/21/97

20c. Location - City or Town, State

OAKLAND, MARYLAND

21. Signature of Funeral Service Licensee

 MO0167

22. Name and Address of Facility

P.O. BOX 243  
DURST FUNERAL HOME - OAKLAND, MD 2155023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Congestive Heart Failure

Approximate  
Interval Between  
Onset and Death

2 days

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

H26154

29d. Date signed (Month, Day, Year)

FEBRUARY 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

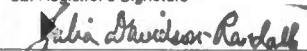
P. DANIEL MILLER, D.O. 2255 G.W. PLAZA

RT. 135E OAKLAND, MD 21550

31. Date filed (Month, Day, Year)

FEB 20 1997

32. Registrar's Signature

State  
Registrar

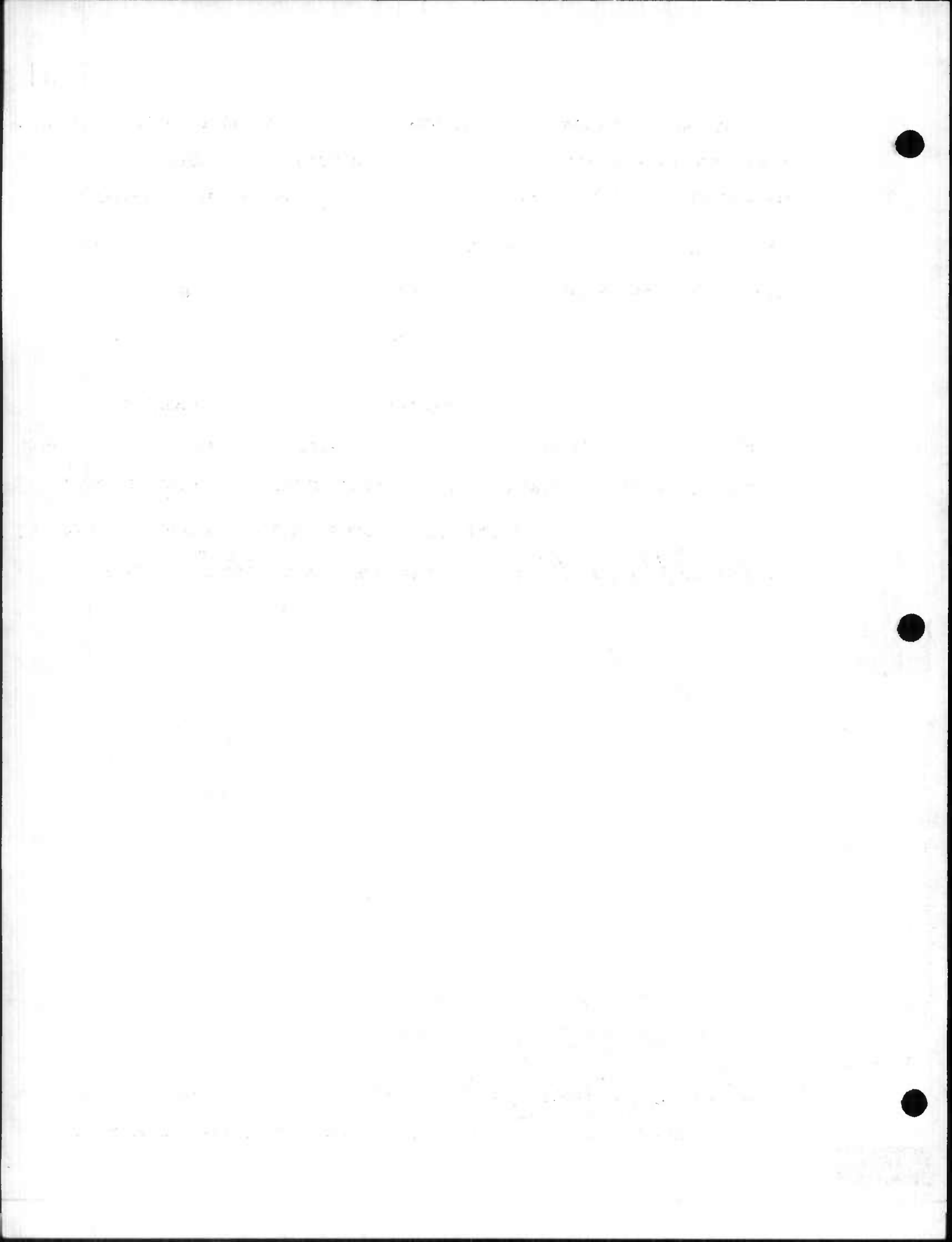
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06332

## Certificate of Death

Reg. No.

|  |   |  |   |   |  |  |   |  |
|--|---|--|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Robert Baile, III</b>  |  |   |   | 2. Date of Death<br>Month <b>February</b> Day <b>8</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>8:32 PM</b>  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>Union Memorial Hospital</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>  |  | 4c. County of Death<br><b>Baltimore City</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>161-07-8800</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>March 27, 1913</b>                                |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>   |  | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Carroll</b>  |  | 10c. City, Town or Location<br><b>Sykesville</b>  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>7200 Third Avenue</b>  |   | 10f. Zip Code<br><b>21784</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>                                       |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>aide to U.S. postal inspector</b>   |   | 16b. Kind of Business/Industry<br><b>U.S. Post Office</b>  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Robert Baile, Jr.</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Fannie Mae Martin</b>  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Sally Ann Stuart / daughter</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10614 Judy Lane, Columbia, MD 21044</b>  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Olivet Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>Frederick, Maryland</b>  |  | 20d. Date<br><b>2/12/97</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |   |   | 22. Name and Address of Facility<br><b>Stauffer Funeral Homes, P.A.<br/>1621 Opossumtown Pike, Frederick, Maryland 21702</b>   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. Acute Myocardial Infarction</b><br>Due to (or as a consequence of):<br><b>b. Coronary artery disease</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |   |  |  |   |  |
|  | 23b. Approximate Interval Between Onset and Death<br><b>4 days 5 years</b>  |  |   |   |  |  |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Parkinsons Disease</b>   |  |   |   |  |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |   |   |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |   |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |   |  |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  |   |  | 28d. Describe how injury occurred   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
|  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |  |  |   |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |   |  |   | 29c. License number<br><b>AT2438946-C24</b>     |  | 29d. Date signed (Month, Day, Year)<br><b>February 8, 1997</b> |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>STACEY SHORR 201 E Univ. Parkway Baltimore MD 21218</b>   |   |  |   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 10 1997</b>  |   |  |   | 32. Registrar's Signature<br><i>[Signature]</i> |  |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06333

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rose A. Burdis

2. Date of Death

February 7, 1997

3. Time of Death

3:30 AM

4a. Facility Name (If not institution, give street and number)

2034 Firetower Lane

4b. City, Town, or Location of Death

Ijamsville

4c. County of Death

Frederick

5. Social Security Number

577-26-7436

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 26, 1904

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Ijamsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2034 Firetower Lane

10f. Zip Code

21754

10g. Citizen of What Country?

American

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Budget Clerk

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Onofrio Carollo

18. Mother's Name (First, Middle, Maiden Surname)

Giuseppina Lodato

19a. Informant's Name/Relationship (Type, Print)

Barbara Manard - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2034 Firetower Lane, Ijamsville, Maryland 21754

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Arlington National Cem.

Date

2/13/97

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

James L. Williams

22. Name and Address of Facility

Olin L. Molesworth, P.A., Funeral Home

26401 Ridge Road, Damascus, Maryland 20872

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. Metastatic Colon Cancer  
Due to (or as a consequence of):Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Previous C.V.A. 1991

Hypothyroid 1990, M.I. 6/94  
CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

James S. Grissom, M.D.

29c. License number

D21944

29d. Date signed (Month, Day, Year)

February 7, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

James S. Grissom, M.D. 300 W.9th Street, Frederick, Md.

31. Date filed (Month, Day, Year)

FEB 10 1997

32. Registrar's Signature

James S. Grissom, M.D.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1941-1942

1941-1942

1941-1942

1941-1942

1941-1942

1941-1942

1941-1942

1941-1942

1941-1942

1941-1942



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06334

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SOUNTHONE BANNAVONG

2. Date of Death

February 5, 1997

3. Time of Death

4:00 A.M.

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Funeral  
Director

5. Social Security Number

218-11-2367

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

52

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 9, 1944

9. Birthplace (State or Foreign Country)

Laos

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Temple Hills

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6802 Temple Hill Road

10f. Zip Code

20748

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Asian

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Mail Clerk

16b. Kind of Business/Industry

Social & Health  
Services

17. Father's Name (First, Middle, Last)

Thaou Bannavong

18. Mother's Name (First, Middle, Maiden Summa)

Fuey Nuensouk

19a. Informant's Name/Relationship (Type, Print)

James Bannavong / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5501 Hiland Avenue, Lanham, Maryland 20706

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

Feb. 15, 1997

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Michael P. Kutta M00348

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/  
Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave.  
Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Upper Gastrointestinal Bleeding

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 day

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Esophageal Varices

Due to (or as a consequence of):

6 months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☒ Yes ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?  
☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Michael P. Boyle MD

29c. License number

D46141

29d. Date signed (Month, Day, Year)

2/5/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael P. Boyle, M.D. Johns Hopkins 600 N. Wolfe St. Baltimore MD

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #7,2/20/97,GF, Mont.Co.

Certificate of Death

Reg. No.

97 06335

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jeanne C. Barrett

2. Date of Death

Month Day Year  
February 15, 1997

3. Time of Death

14:30

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

531-32-5251

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60 61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 19, 1935

9. Birthplace (State or Foreign Country)

Washington

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

19301 Watkins Mill Road

10f. Zip Code

20879

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Writer

16b. Kind of Business/Industry

Publications

17. Father's Name (First, Middle, Last)

William Chaussee

18. Mother's Name (First, Middle, Maiden Surname)

Helen Jensen

19a. Informant's Name/Relationship (Type, Print)

Loris Mullins / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2301 Diamond Head Way, Oxnard, California 93030

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Feb. 20, 1997  
Montgomery Crematorium, Inc.

Date

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Michelle P. Hutto M00348

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/  
Rockville, Inc., 300 W. Montgomery Avenue  
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Perforated Bowel

3 days

Due to (or as a consequence of):

b. Small Cell Lung Cancer

3 months

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

044157

29d. Date signed (Month, Day, Year)

February 16, 1997

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

IRA BERGER M.D. 809 VEINS MILL ROAD, ROCKVILLE, MARYLAND 20851

31. Date filed (Month, Day, Year)

FEB 20 1997

32. Registrar's Signature

John Davidson-Pondell

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06336

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JEROME

2. Date of Death

Month

Day

Year

3. Time of Death

11:50 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

577-28-8025

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Mar. 13, 1924

9. Birthplace (State or Foreign Country)

Connecticut

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street end Number

4716 Listra Road

10f. Zip Code

20853

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Editor

16b. Kind of Business/Industry

Newspaper

17. Father's Name (First, Middle, Last)

Morris Boin

18. Mother's Name (First, Middle, Maiden Surname)

Mary King

19a. Informant's Name/Relationship (Type, Print)

Sonia Boin

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

4716 Listra Rd. Rockville, MD 20853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Judean Memorial Gardens

Date

2/14

20c. Location - City or Town, State

Olney, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Edward Sagel Funeral Direction

1091 Rockville Pike Rockville MD 20852

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. Non-Hodgkin's lymphoma  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

2 years

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street end Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D21531

29d. Date signed (Month, Day, Year)

Feb. 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Peter Pushkas 11510 Old Georgetown Rd. Rockville MD 20852

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



97 06337

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EDWARD ALLAN BRAGER</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>FEB</b> DAY <b>12</b> YEAR <b>97</b>   |  | 3. TIME OF DEATH<br><b>1352 P M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>212-36-8938</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (in yrs. last birthday)<br><b>59</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>04/27/1937</b>                                    |   |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>7401 WEST LAKE TERRACE #401</b>   |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>BETHESDA</b>  |  | 8c. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |   |
| 9a. STATE<br><b>MARYLAND</b>   |  |  |  | 9b. COUNTY<br><b>MONTGOMERY</b>   |  | 9c. CITY, TOWN OR LOCATION<br><b>BETHESDA</b>   |   |
| 10a. STREET AND NUMBER<br><b>7401 WEST LAKE TERRACE #401</b>   |  |  |  | 10b. ZIP CODE<br><b>20817-6565</b>  |  | 10c. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>                                       |   |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 8+) <input checked="" type="checkbox"/>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>ENGINEER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>ELECTRICAL</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>MAURICE B. BRAGER</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ELINOR LEVIN</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ELINOR LEVIN/MOTHER</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1801 EAST JEFFERSON ST #210, ROCKVILLE, MD 20852</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>BETH TFILOH</b>  |  | 20c. DATE<br><b>2/14</b>  |  | 20d. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>                           |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br/>1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. MYOCARDIAL INFARCTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>ACUTE</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES MELLITUS</b>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |   |   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><b>007099</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>FEB 12 97</b>                                     |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>FRANCIS C MAYLE 10215 FERNWOOD RD BETHESDA MD 20817</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 18 1997</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06338

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) OPAL E. BRASHERS  
 2. Date of Death FEB. 14, 1997 Year  
 3. Time of Death 4:15 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number) CIRCLE MANOR NURSING HOME  
 4b. City, Town, or Location of Death KENSINGTON  
 4c. County of Death MONTGOMERY

5. Social Security Number 491 60 7803  
 6. Sex ☐ M ☒ F  
 7. Age (In yrs. last birthday) 88 Yrs.  
 8. Date of Birth (Month, Day, Year) DEC. 31, 1908  
 9. Birthplace (State or Foreign Country) MISSOURI

Usual Residence of Decedent

10a. State MD.  
 10b. County MONTGOMERY  
 10c. City, Town or Location WHEATON  
 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number 10851 BUCKNELL DRIVE  
 10f. Zip Code 20902  
 10g. Citizen of What Country? U.S.A.

11. Marital Status  
☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced  
 12. Was Decedent Ever in U.S. Armed Forces?  
☐ Yes ☒ No  
 If Yes, Give Year or Dates:  
 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:  
 14. Race - American Indian, Black, White, etc.  
 Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)  
 Elementary/Secondary (0-12) 12 Collage (1-4 or 5+)  
 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER  
 16b. Kind of Business/Industry OWN HOME

17. Father's Name (First, Middle, Last) CIARENCE RODGERS  
 18. Mother's Name (First, Middle, Maiden Surname) LIZZIE HAWKER

19a. Informant's Name/Relationship (Type, Print) ROGER BRASHERS/SON  
 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS 10e

20a. Method of Disposition  
☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)  
 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory  
 Data Feb. 18, 1997  
 20c. Location - City or Town, State Alexandria, Va.

21. Signature of Funeral Service Licensee  
 22. Name and Address of Facility  
 TAKOMA FUNERAL HOME INC 254 CARROLL ST. N.W. WASHINGTON, D.C. 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
 Immediate Cause (Final disease or condition resulting in death) a. Breast cancer  
 Due to (or as a consequence of):  
 b. Due to (or as a consequence of):  
 c. Due to (or as a consequence of):  
 d. Due to (or as a consequence of):  
 Approximately Interval Between Onset and Death years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?  
☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?  
☐ Yes ☒ No  
 24b. Were autopsy findings available prior to completion of cause of death?  
☐ Yes ☐ No

25. Was case referred to medical examiner?  
☐ Yes ☒ No  
 26. Place of Death (Check only one)  
 Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA  
 Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death  
☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide  
 28a. Date of Injury (Month, Day, Year)  
 28b. Time of injury M  
 28c. Injury at Work? ☐ Yes ☒ No  
 28d. Describe how injury occurred  
 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)  
☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier  
 29c. License number D34032  
 29d. Date signed (Month, Day, Year) FEB. 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
 JEANNE P. ASHER MD 3720 FARRAGUT AVE KENSINGTON MD 20895

31. Date filed (Month, Day, Year) FEB 19 1997  
 32. Registrar's Signature Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or item 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06339

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lucille Helppie Brown

2. Date of Death

Month Day Year  
February 17, 1997

3. Time of Death

8:30 AM

4a. Facility Name (If not institution, give street and number)

415 Russell Ave., # 506

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

226-84-3928

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 22, 1915

9. Birthplace (State or Foreign Country)

Minnesota

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

415 Russell Avenue, # 506

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No  
Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Andrew

Helppie

18. Mother's Name (First, Middle, Maiden Surname)

Matilda

Johnson

19a. Informant's Name/Relationship (Type, Print)

P. Stanley Brown/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

415 Russell Avenue, # 506, Gaithersburg, MD. 20877

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

2/17/97

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Michael D. Culibron

22. Name and Address of Facility

DeVol Funeral Home

10 E. Deer Park Dr., Gaithersburg, MD. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Aortic Stenosis

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart failure

Hypertension

Aortic Stenosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Byrl D. Johnson M.D.

29c. License number

D-19042

29d. Date signed (Month, Day, Year)

February 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Byrl D. Johnson M.D.

911 Russell Avenue Gaithersburg, Maryland 20879

31. Date filed (Month, Day, Year)

FEB 19 1997

32. Registrar's Signature

Jill Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06340

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sara Hammond Burns

2. Date of Death

February 18, 1997

3. Time of Death

6:20 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

579-36-3709

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 27, 1918

9. Birthplace (State or Foreign Country)

Tennessee

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12520 Two Farm Drive

10f. Zip Code

20904

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
416a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William S. Hammond

18. Mother's Name (First, Middle, Maiden Surname)

Mary Bass

19a. Informant's Name/Relationship (Type, Print)

Thomas Burns / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12520 Two Farms Drive, Silver Spring, Maryland 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

National Memorial Park

Date

2/21/97

20c. Location - City or Town, State

Falls Church, Virginia

21. Signature of Funeral Service Licensee

▶ Alan J. Donnell

22. Name and Address of Facility

Hines-Rinaldi Funeral Home  
11800 New Hampshire Avenue  
Silver Spring, Maryland 2090423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Asthmatic Bronchitis

Mitral Valve Prolapse

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

▶ John H. Sullivan, MD

29c. License number

D25080

29d. Date signed (Month, Day, Year)

2/18/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frank N. Gravino, 10303 Georgia Ave, Silver Spring, MD

31. Date filed (Month, Day, Year)

FEB 21 1997

32. Registrar's Signature

▶ John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06341

## Certificate of Death

Reg. No.

|  |  |   |  |   |  |  |  |  |   |   |   |
|--|--|---|--|---|--|--|--|--|---|---|---|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>PAUL JOSEPH BROWN</b>                         |   |  |   |  |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>15</b> Year <b>1997</b> |  | 3. Time of Death<br><b>8:00 AM</b>                          |   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Holy Cross Hospital</b> |   |  |   |  |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>             |  | 4c. County of Death<br><b>Montgomery</b>                    |   |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>499-12-3796</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs. |  | 8. Date of Birth (Month, Day, Year)<br><b>April 18, 1924</b>             |  | 9. Birthplace (State or Foreign Country)<br><b>Missouri</b> |   |   |
|  | Usual Residence of Decedent  |   |  |   |  |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Montgomery</b>                            |   | 10c. City, Town or Location<br><b>Silver Spring</b> |
| To Be Completed by Funeral Director                                  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>10611 Glenwild Road</b>  |  | 10f. Zip Code<br><b>20901</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |   |   |
|  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1943-1944</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |   |   |
|  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>5+</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Administrative Engineer</b>   |  | 16b. Kind of Business/Industry<br><b>U.S. Government</b>   |  |  |   |   |   |
|  |  | 17. Father's Name (First, Middle, Last)<br><b>Joseph Brown</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lucille Kasten</b>  |  |  |  |  |   |   |   |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Gloria Brown</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10611 Glenwild Rd, Silver Spring, MD 20901</b>  |  |  |  |  |   |   |   |
|  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parklawn Memorial Park</b>   |  | Date<br><b>2/19/97</b>   |  | 20c. Location - City or Town, State<br><b>Rockville, MD</b>  |   |   |   |
|  |  | 21. Signature of Funeral Service Licensee<br><b>James S. Dooly</b>  |  | 22. Name and Address of Facility<br><b>Collins Funeral Home</b><br><b>500 University Blvd. West, Silver Spring, MD 20901</b>  |  |  |  |  |   |   |   |
|  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>GASTROINTESTINAL HEMORRHAGE</b><br>Due to (or as a consequence of):<br><b>METASTATIC PANCREATIC CARCINOMA</b><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death<br><b>2 DAYS</b><br><b>2 YEARS</b>   |  |  |  |  |   |   |   |
| Physician<br>/Medical<br>Examiner                                    |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |   |
|  |  |   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |   |   |
|  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   | 28d. Describe how injury occurred   |   |
|  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |   |   |   |
|  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                             |  | 29b. Signature and title of certifier<br><b>James C. Brown, MD</b>  |  | 29c. License number<br><b>D07285</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 15, 1997</b>  |   |   |   |
| State Registrar  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JAMES A. BROWN, MD 9707 MEDICAL CENTER DRIVE, ROCKVILLE, MD 20850</b>  |  | 31. Date filed (Month, Day, Year)<br><b>FEB 19 1997</b>   |  | 32. Registrar's Signature<br><b>Jill Davidson-Randall</b>  |  |  |   |   |   |
|  |  |   |  |   |  |  |  |  |   |   |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06342

## Certificate of Death

Reg. No.

|  |   |   |   |  |  |  |  |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |
|--|---|---|---|--|--|--|--|--|---|----|-----------------------------|---|----|--------------------------|---------|----|-----------|---------|----|-----------------|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>ALICE EMMA BURGOS   |   |   |  | 2. Date of Death<br>Month FEB Day 21 Year 1997   |  | 3. Time of Death<br>06:03A                                       |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |
|  | 4a. Facility Name (If not Institution, give street and number)<br>Union Hospital  |   |   |  | 4b. City, Town, or Location of Death<br>Elkton   |  | 4c. County of Death<br>Cecil                                     |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |
| Funeral<br>Director  | 5. Social Security Number<br>221-16-4219  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>81 Yrs.      | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>4/24/1915                 | 9. Birthplace (State or Foreign Country)<br>Cecil Co., MD                                      |   |    |                             |   |    |                          |         |    |           |         |    |                 |
|  | Usual Residence of Decedent   |   |   |  |  |  |  |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |
| To Be Completed by Funeral Director  | 10a. State<br>DE  |   | 10b. County<br>New Castle   |  | 10c. City, Town or Location<br>Wilmington  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |    |                             |   |    |                          |         |    |           |         |    |                 |
|  | 10e. Street and Number<br>2707 North Harrison Street  |   |   |  | 10f. Zip Code<br>19806   |  | 10g. Citizen of What Country?<br>USA                             |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Housekeeper                          |  |  | 16b. Kind of Business/Industry<br>Healthcare/Hospital  |  |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |
|  | 17. Father's Name (First, Middle, Last)<br>John Franks  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Laura Ayers   |  |  |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>Gilbert M. Watts Jr. - Son  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8 Littleworth Lane, New Castle, DE 19720  |  |  |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gracelawn Memorial Park   |  | Date<br>2/25/97  |  | 20c. Location - City or Town, State<br>New Castle, Delaware      |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |
|  | 21. Signature of Funeral Service Licensee<br>Frank C. Mayer Jr.   |   | 22. Name and Address of Facility<br>Spicer-Mullikin Funeral Homes, Inc.<br>1000 N. DuPont Pkwy, New Castle, DE 19720                              |  |  |  |  |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |  |  |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |
|  | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Acute Myocardial Infarction</td> <td>Approximate Interval Between Onset and Death<br/>1 hr.</td> </tr> <tr> <td>b.</td> <td>Congestive Heart Failure</td> <td>10 days</td> </tr> <tr> <td>c.</td> <td>Pneumonia</td> <td>10 days</td> </tr> <tr> <td>d.</td> <td>Aortic Stenosis</td> <td></td> </tr> </table> |   |   |  |  |  |  |  | Immediate Cause (Final disease or condition resulting in death) | a. | Acute Myocardial Infarction | Approximate Interval Between Onset and Death<br>1 hr. | b. | Congestive Heart Failure | 10 days | c. | Pneumonia | 10 days | d. | Aortic Stenosis |
| Immediate Cause (Final disease or condition resulting in death)  | a.  | Acute Myocardial Infarction   | Approximate Interval Between Onset and Death<br>1 hr.   |  |  |  |  |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |
|  | b.  | Congestive Heart Failure  | 10 days   |  |  |  |  |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |
|  | c.  | Pneumonia   | 10 days   |  |  |  |  |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |
|  | d.  | Aortic Stenosis   |   |  |  |  |  |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |
|  |   |   |   |  |  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |
|  |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M                       |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |  |  |  |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |
| 29b. Signature and title of certifier<br>Jui Chih Hsu MD   |   | 29c. License number<br>D04823   |   | 29d. Date signed (Month, Day, Year)<br>2/21/97 |  |  |  |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Jui Chih Hsu, MD., 223 W. Main St., Elkton, MD 21921   |   |   |   |  |  |  |  |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |
| 31. Date filed (Month, Day, Year)<br>FEB 25 1997   |   | 32. Registrar's Signature<br>Jelia Davidson-Randall   |   |  |  |  |  |  |   |    |                             |   |    |                          |         |    |           |         |    |                 |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06343

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Bien

2. Date of Death

February 18, 1997

3. Time of Death

1:50 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Fairhaven Life Care Community

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll County

5. Social Security Number

214-40-5181

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 3, 1905

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll County

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7200 Third Avenue

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Handicap Education

17. Father's Name (First, Middle, Last)

Thomas Lloyd Hemmick

18. Mother's Name (First, Middle, Maiden Surname)

Mary Elizabeth Herpel

19a. Informant's Name/Relationship (Type, Print)

Fairhaven

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7200 Third Avenue Sykesville, MD 21784

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation Serv. 2/19/97

Data

20c. Location - City or Town, State

Hampstead, MD

21. Signature of Funeral Service Licensee

Bryan A. Haight

22. Name and Address of Facility

HAIGHT FUNERAL HOME &amp; CHAPEL (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Coronary Vessel Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1970

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert L. Mott, MD

29c. License number

052002

29d. Date signed (Month, Day, Year)

2/18/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert L. Mott

114 Business Center Dr. Rockville, MD

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 20 1997

32. Registrar's Signature

John Anderson-Randall

211PC

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06344

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANN GLIDDEN HOPPER BROWN

2. Date of Death

February 22 1997

3. Time of Death

5:00 AM

4a. Facility Name (If not institution, give street and number)

3605 Shady Rest Road

4b. City, Town, or Location of Death

Ft Washington

4c. County of Death

PRINCE GEORGE'S

Funeral  
Director

5. Social Security Number

579-22-6711

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUG 30 1909

9. Birthplace (State or Foreign Country)

Montana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Fort Washington

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

3605 Shady Rest Road

10f. Zip Code

20744

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Samuel H. Glidden

18. Mother's Name (First, Middle, Maiden Surname)

Mary Johnson Glidden

19a. Informant's Name/Relationship (Type, Print)

Bennie H. Brown (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3605 Shady Rest Road Ft Washington, MD 20744

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory 2-23-97

Date

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

MO0173

22. Name and Address of Facility

J.H. Eberwein Mortuary  
4433 White Pls La White Pls., MD 2069523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D23826

29d. Date signed (Month, Day, Year)

February 23, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Glenn Edgecombe MD 7700 Old Branch Ave #B-210 Clinton, Maryland 20735

31. Date filed (Month, Day, Year)

FEB 24 1997

32. Registrar's Signature

Julia Davidson Randall

State  
Registrar

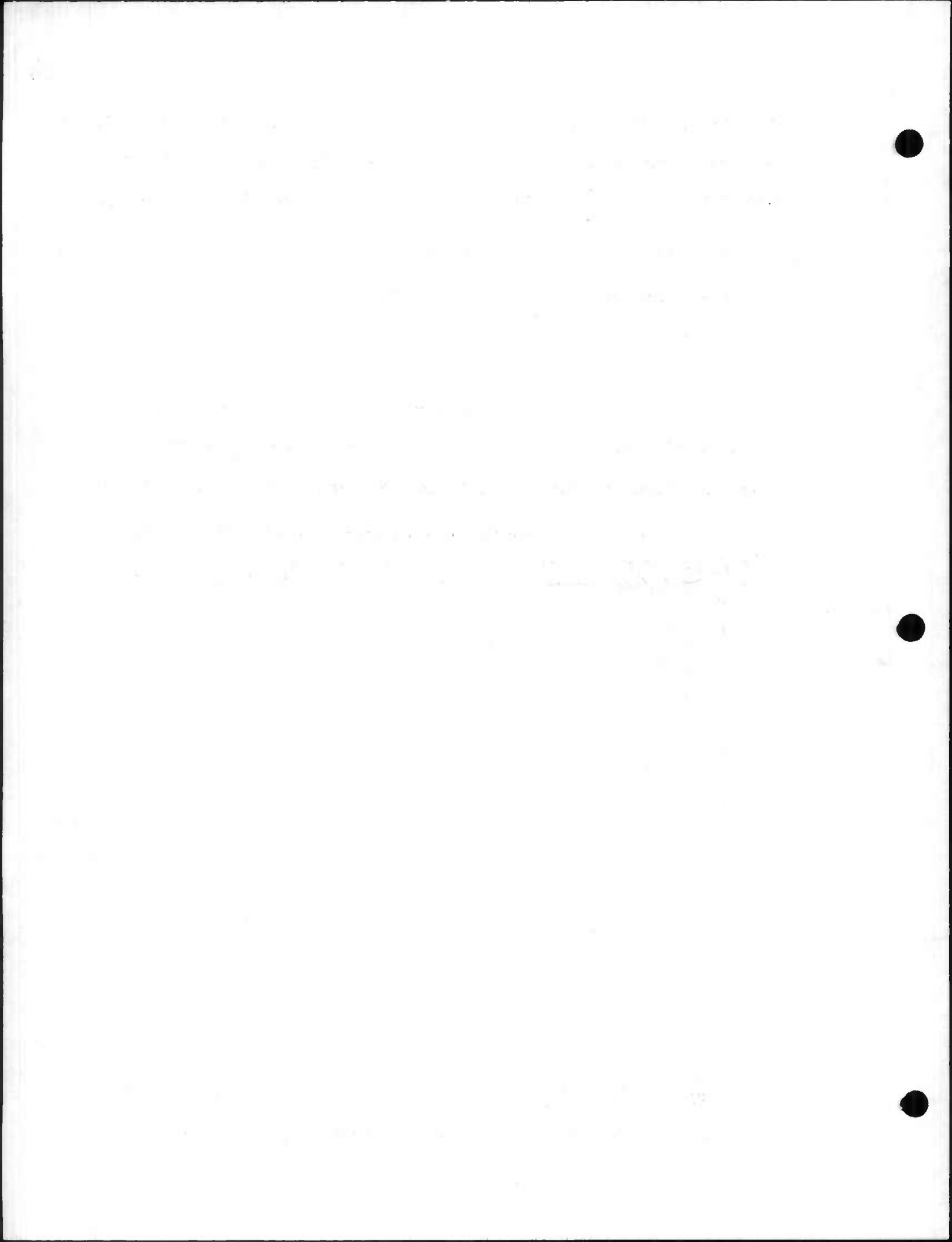
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06345

|   |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>GEORGIA MAE CRIGGER  |  |  |  | 2. Date of Death<br>Month Day Year<br>FEBRUARY 13, 1997  |  | 3. Time of Death<br>4:35 P.M.   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>133 NORTH MEADOW DRIVE   |  |  |  | 4b. City, Town, or Location of Death<br>GLEN BURNIE  |  | 4c. County of Death<br>ANNE ARUNDEL   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>218-36-0423   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>81 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>5-8-1915   |  |
|   | 9. Birthplace (State or Foreign Country)<br>SMYTH COUN. VA.  |  | 10a. State<br>MD   |  | 10b. County<br>ANNE ARUNDEL  |  | 10c. City, Town or Location<br>GLEN BURNIE  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 10e. Street and Number<br>133 NORTH MEADOW DR.   |  | 10f. Zip Code<br>21061  |  |
|   | 10g. Citizen of What Country?<br>USA   |  |  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+)                                  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>LPN   |  |  |  | 16b. Kind of Business/Industry<br>NURSING  |  | 17. Father's Name (First, Middle, Last)<br>WILLIAM HAYES  |  |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)<br>CAROLINE HAGA   |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br>SHELVA ENGLE   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>133 NORTH MEADOW DRIVE GLEN BURNIE MD 21061          |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>GLEN HAVEN MEMORIAL PK   |  | 20c. Location - City or Town, State<br>GLEN BURNIE, MD.   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br>SINGLETON FUNERAL HOME<br>1 SECOND AVE S.W. GLEN BURNIE, MD. 21061   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Congestive Heart Failure<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  | Approximate Interval Between Onset and Death<br>2 days   |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Ischemic heart disease   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |   |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28e. Date of Injury (Month, Day Year)<br>28f. Time of Injury<br>M 28g. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28h. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 28i. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
|   | 29b. Signature and title of certifier<br>  |  |  |  | 29c. License number<br>D23824  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)<br>February 14, 1997   |  |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>BASAM KHANDELWAL, 1600 S. Crown Highway, Glen Burnie, MD   |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br>FEB 18 1997   |  |  |  | 32. Registrar's Signature<br>  |  |   |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06346

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alton H. Cunningham

2. Date of Death

Month February Day 16, Year 1997

3. Time of Death

3:50 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

151 Truckhouse Road

4b. City, Town, or Location of Death

Severna Park

4c. County of Death

Anne Arundel

5. Social Security Number

217-03-3786

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov 6, 1919

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10e. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

151 Truckhouse Road

10f. Zip Code

21146

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Self-Employed Owner

16b. Kind of Business/Industry

Mechanical  
Contractor

17. Father's Name (First, Middle, Last)

Samuel Cunningham

18. Mother's Name (First, Middle, Maiden Surname)

Nora Heckenberg

19a. Informant's Name/Relationship (Type, Print)

Dolores Cunningham/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

151 Truckhouse Rd., Severna Park, MD 21146

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory

Date

Feb 19  
1997

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home  
495 Gov Ritchie Hwy Severna Park, MD 2114623a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Metastatic colon cancer

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. colon cancer

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

severe atherosclerosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D30568

29d. Date signed (Month, Day, Year)

2/17/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. SHOBHA D. REDDY 7845 OAKWOOD RD STE 204 Glen Burnie Md. 21061

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

State  
Registrar

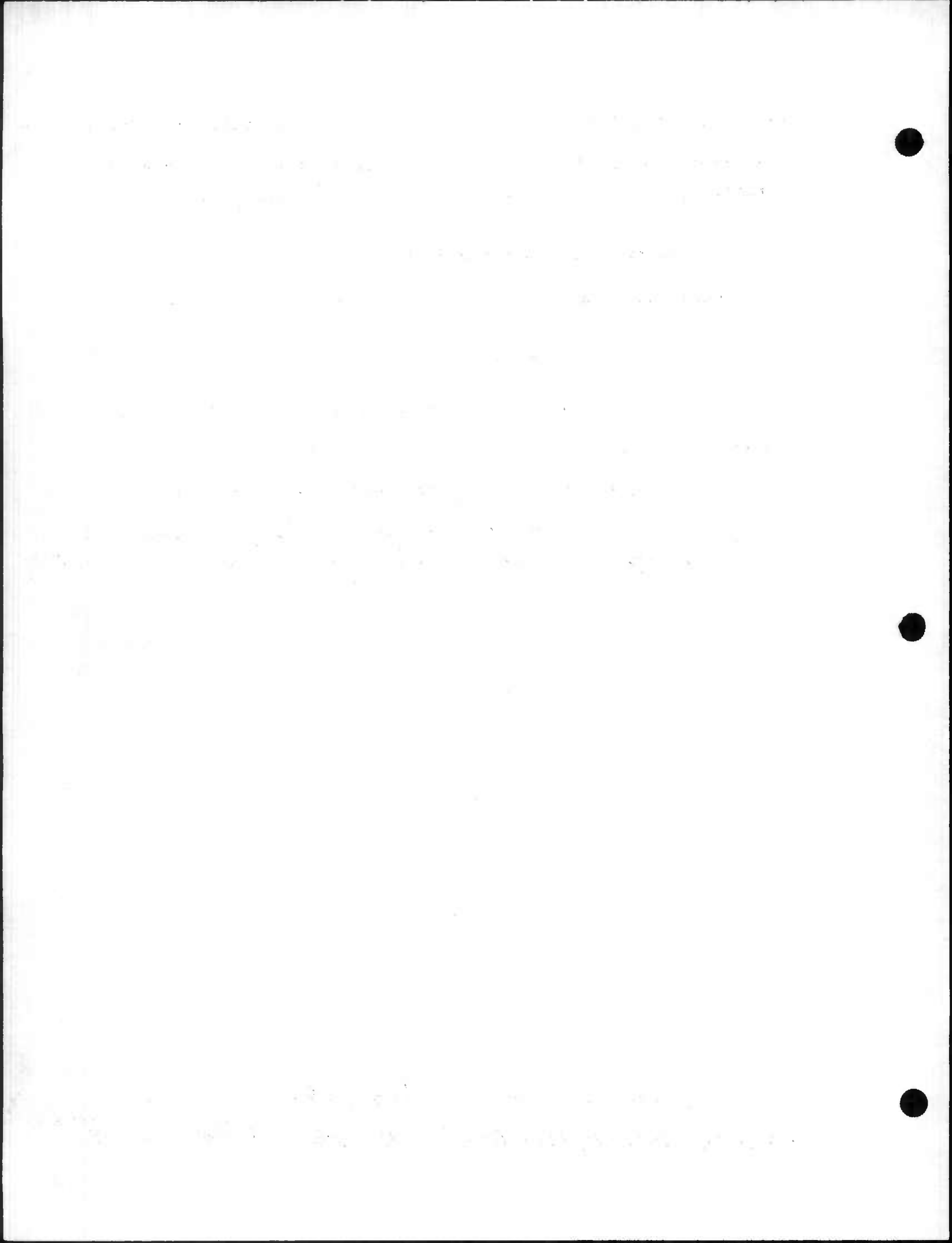
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06347

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Norwood Augustos Caldwell Sr.

2. Date of Death

Month Day Year  
02 11 1997

3. Time of Death

4:23 pm

4a. Facility Name (If not institution, give street and number)

Box 23753 St. Michaels Rd.

4b. City, Town, or Location of Death

St. Michaels

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

218-12-1799

8. Sex

M 2 F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
04/12/1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Talbot

10c. City, Town or Location

St. Michaels

10d. Inside City Limits

Yes 2 No

10e. Street and Number

Box 23753

10f. Zip Code

21663

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Custodian

16b. Kind of Business/Industry

Yacht Club

17. Father's Name (First, Middle, Last)

Charles D. Caldwell

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Adams

19a. Informant's Name/Relationship (Type, Print)

Norwood A. Caldwell

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23739 St. Michaels Rd. St. Michaels, Md.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Richardson Cemetery 2/15/97 Easton, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

John A. Prince

22. Name and Address of Facility

Bennie Smith Funeral Home  
P.O. Box 1687 Easton, Md. 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gastrointestinal Hemorrhage

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

L. Thomas Divilio, MD

29c. License number

D24769

29d. Date signed (Month, Day, Year)

2/13/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. Thomas Divilio, MD PO Box 822 Easton, MD 21601

31. Date filed (Month, Day, Year)

FEB 19 1997

32. Registrar's Signature

Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06348

|  |   |  |   |  |   |  |
|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Robert Christian</b>   |  | 2. Date of Death<br>Month <b>February</b> Day <b>12</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>3:00 a.m.</b>  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>Dorchester General Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Cambridge</b>  |  | 4c. County of Death<br><b>Dorchester</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>231-26-7819</b>   |  | 6. Sex<br><b>2</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs. | 8. Date of Birth (Month, Day, Year)<br><b>12/01/1923</b>  | 9. Birthplace (State or Foreign Country)<br><b>Unknown</b> |
|  | Usual Residence of Decedent   |  |   |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Dorchester</b>  |  | 10c. City, Town or Location<br><b>Cambridge</b>   |  |
|  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |   |  |
|  | 10e. Street and Number<br><b>525 Glenburn Ave.</b>  |  | 10f. Zip Code<br><b>21613</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |   |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Unknown</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Unknown</b>                       |  | 16b. Kind of Business/Industry<br><b>Unknown</b>  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Unknown</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Unknown</b>   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mac Area Agency On Aging</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1504 Riverside Dr. Salisbury, Md. 21801</b>   |  |   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Capitol Crematory</b>  |  | 20c. Location - City or Town, State<br><b>2/13/97 Dover, Del.</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Bennie Smith Funeral Home<br/>P.O. Box 1687 Easton, Md. 21601</b>  |  |   |  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Pneumonia</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Dementia</b><br><b>Hx of Seizure Disorder</b><br>Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><b>2 days</b> |   |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia</b><br><b>Hx of Seizure Disorder</b>   |   |  |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |  |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   |  |   |  |   |  |
| 28a. Date of Injury (Month, Day, Year)<br><b>2/13/97</b>   |   |  |   |  |   |  |
| 28b. Time of injury<br><b>M</b>  |   |  |   |  |   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |   |  |
| 28d. Describe how injury occurred  |   |  |   |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |   |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |   |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |  |   |  |   |  |
| 29b. Signature and title of certifier<br><br><b>Elyse Tanman</b>   |   |  |   |  |   |  |
| 29c. License number<br><b>D14349</b>   |   |  |   |  |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>2/12/97</b>  |   |  |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Elyse Tanman M.D. 15 Franklin St. Cambridge, MD 21613</b>   |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 19 1997</b>  |   |  |   |  |   |  |
| 32. Registrar's Signature<br>  |   |  |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06349

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Janice L. Christopher

2. Date of Death

Feb. 14<sup>Day</sup> 1997<sup>Year</sup>

3. Time of Death

1:25 PM

4a. Facility Name (If not institution, give street and number)

Memorial Hospital at Easton

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

159-28-1493

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 11, 1935

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Preston

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

20750 Dover Bridge Road

10f. Zip Code

21655

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Nurse's Aide

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Robert W. Fiessner

18. Mother's Name (First, Middle, Maiden Surname)

Hazel Fiessner (Hanbury)

19a. Informant's Name/Relationship (Type, Print) Husband  
Claude R. Christopher19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
20750 Dover Bridge Rd., Preston, MD 21655

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Jr. Order Cemetery

Date

2/18

20c. Location - City or Town, State

Preston, MD

21. Signature of Funeral Service Licensee

*M. E. Newman*

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home  
200 S. Harrison St., Easton, MD 2160123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. lung cancer

Due to (or as a consequence of):

c. Diabetes mellitus

Due to (or as a consequence of):

d. Coronary artery disease

Approximate  
Interval Between  
Onset and Death

1 day

2 months

years

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diverticulosis of colon &amp; angiodysplasia

Peripheral neuropathy.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

*S. Ali*

29c. License number

D46020

29d. Date signed (Month, Day, Year)

2/14/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Syed I. Ali, MD, 506 Idlewild Avenue, Easton, MD 21601

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

*S. Ali*

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06350

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |  |   |  |  |  |
|---|--|--|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Willard Warren Cox, Sr.  |  |   |  | 2. Date of Death<br>Month Day Year<br>Feb. 25, 1997   |  |   |  | 3. Time of Death<br>3:30 PM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>14515 Thornton Mill Rd.  |  |   |  | 4b. City, Town, or Location of Death<br>Sparks  |  |   |  | 4c. County of Death<br>Baltimore   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>168-14-1027   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>75 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Aug. 4, 1921   |  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania   |  |
|   | Usual Residence of Decedent  |  |   |  |   |  |   |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br>MD   |  | 10b. County<br>Baltimore  |  | 10c. City, Town or Location<br>Sparks   |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br>14515 Thornton Mill Rd.  |  |   |  | 10f. Zip Code<br>21152  |  | 10g. Citizen of What Country?<br>U.S.A.   |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Carpenter  |  |   | 16b. Kind of Business/Industry<br>Home Improvement               |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Ralph Hamilton Cox  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elva Heaps   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Dorothy Cox / Wife   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>14515 Thornton Mill Rd., Sparks, MD 21152  |  |   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Bethlehem Steltz Cemetery   |  | 20c. Date<br>Feb 28, 1997   |  | 20d. Location - City or Town, State<br>Glen Rock, PA  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>J.J. Hartenstein  |  |   |  | 22. Name and Address of Facility<br>J.J. Hartenstein Mortuary, Inc.<br>24 Second St., New Freedom, PA 17349   |  |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. CVA<br>Due to (or as a consequence of):<br>b. ASCVD<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.       |  |   |  |   |  |   |  |  |  |
|   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   |  |  |  |
| State Registrar                               | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>Robert Stoltz, MD  |  | 29c. License number<br>D30910   |  | 29d. Date signed (Month, Day, Year)<br>2/26/97  |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Robert Stoltz 1447 York Rd. Lutherville, MD  |  |   |  |   |  |   |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br>MAR 05 1997   |  | 32. Registrar's Signature<br>John A. ...  |  |   |  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06351

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth E. Creek

2. Date of Death

Month Day Year  
Feb. 25 1997

3. Time of Death

3:00 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

13808 Jenny Lane, N.E.

4b. City, Town, or Location of Death

Little Orleans

4c. County of Death

Allegany

5. Social Security Number

220-32-4206

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 28-03

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Little Orleans

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13808 Jenny Lane, N.E.

10f. Zip Code

21766

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

Allegany County School System

17. Father's Name (First, Middle, Last)

Scott M. Nann

18. Mother's Name (First, Middle, Maiden Surname)

Edith Virginia Creek

19a. Informant's Name/Relationship (Type, Print)

Patricia R. Nicodemus/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13808 Jenny Lane Little Orleans, MD 21766

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Piney Plains U.M. Cemetery 2/27/97 Little Orleans, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Grove Funeral Home, P.A.

P.O. Box 358 Hancock, MD 21750

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

4-5

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

senile dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D11266

29d. Date signed (Month, Day, Year)

Feb. 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard N. Weeks, M.D. 580 Northern Ave. Hagerstown, MD 21742

31. Date filed (Month, Day, Year)

MAR 05 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

E



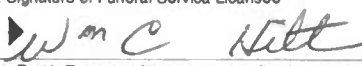
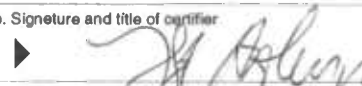

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06352

Reg. No.

|  |  |   |  |  |  |  |  |   |
|--|--|---|--|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Stephen M. Callahan, Jr.</b>                  |   |  |  | 2. Date of Death<br>Month Day Year<br><b>Feb 17 1997</b> |  | 3. Time of Death<br><b>11:15 am</b>  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>College View Center</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Frederick</b> |  | 4c. County of Death<br><b>Frederick</b>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-16-2152</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.   | If Under 1 Year<br>Months Days                           | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Feb 1 1922</b>                                       | 9. Birthplace (State or Foreign Country)<br><b>SC</b>         |
|  | Usual Residence of Decedent  |   |  |  |  |  |  |   |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Frederick</b>   |  | 10c. City, Town or Location<br><b>Frederick</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>400 North Avenue</b>  |  |   |  | 10f. Zip Code<br><b>21701</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales</b>  |  |  | 16b. Kind of Business/Industry<br><b>Selling</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Stephen M. Callahan, Sr.</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Lou Gossett</b>  |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Wm. A. Callahan, II nephew</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16111 Morrow Road, Poolesville, MD 20837</b>   |  |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Monocacy</b>   |  | 20c. Date<br><b>2/19</b>   |  | 20d. Location - City or Town, State<br><b>Beallsville, MD</b>  |  |   |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Hilton Funeral Home<br/>22111 Beallsville Rd. Barnesville, MD 20838</b>   |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Possible Lung cancer</b><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>months</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Parkinson's</b><br><b>Dementia</b>  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred                             |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |  |   |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D27101</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2/18/97</b>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>DR. HALVERSON 1475 TANEY AVE - FREDERICK, MD 21701</b>  |  |   |  |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 18 1997</b>  |  | 32. Registrar's Signature<br>  |  |  |  |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 06353

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gladys Evelyn COX

2. Date of Death

February 14, 1997

3. Time of Death

3:30 AM

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

244-34-8615

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

August 30, 1914

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

990 Waterford Drive

10f. Zip Code

21702

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Bruce

BRIDGES

18. Mother's Name (First, Middle, Maiden Surname)

Lilly

WHITE

19a. Informant's Name/Relationship (Type, Print)

Mrs. Mary C. Costello, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

35 East Second Street, Frederick, Maryland 21701

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory, Feb. 16, 1997

Date

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

Richard E. Draf

M00255

22. Name and Address of Facility

Keeney and Basford P.A. Funeral Home

106 East Church St., Frederick, Md. 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cerebrovascular Accident

Approximate Interval Between Onset and Death

2 Days

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Sean Hunt MD

29c. License number

D 39846

29d. Date signed (Month, Day, Year)

February 14, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Sean Hunt MD 310 West Ninth Street, Frederick, Maryland 21701

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Jane Shudson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06354

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Ann Coulter

2. Date of Death

February 14 97

3. Time of Death

1332

4e. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Funeral  
Director

5. Social Security Number

227-22-0532

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Apr. 21, 1925

9. Birthplace (State or Foreign Country)

Va.

Usual Residence of Decedent

10e. State

Md.

10b. County

Frederick

10c. City, Town or Location

Middletown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7 Larch Lane

10f. Zip Code

21769

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Harold Wagner

18. Mother's Name (First, Middle, Maiden Surname)

Mary Rathman

19a. Informant's Name/Relationship (Type, Print)

Charles S. Coulter (Husband) 7 Larch Lane, Middletown, Md. 21769

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Hebron Cemetery 2/17 Winchester, Va.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald B. Thompson Funeral Home  
31 E. Main St., Middletown, Md. 2176923e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. Ventricular Fibrillation  
Due to (or as a consequence of):b. Dilated Cardiomyopathy  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 minute

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28e. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

M6335

29d. Date signed (Month, Day, Year)

February 14, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Gregory M. Lucas 600 N. Wolfe St., Baltimore

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06355

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edward Samuel CRONE

2. Date of Death

Month Day Year  
February 10, 1997

3. Time of Death

12:57 PM

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

219-20-2203

6. Sex

M 2 ☐ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
October 21, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6269 Ed Crone Lane

10f. Zip Code

21703

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Postal Clerk

16b. Kind of Business/Industry

US Postal Service

17. Father's Name (First, Middle, Last)

Samuel

CRONE

18. Mother's Name (First, Middle, Maiden Surname)

Lee Anna MAIN

19a. Informant's Name/Relationship (Type, Print)

Mrs. Doris Mae Crone, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6269 Ed Crone Lane, Frederick, Maryland 21703

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Saint Lukes Cemetery, Feb. 13, 1997 Feagville, Maryland

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Richard C. C. Basford MD00021

22. Name and Address of Facility

Keeney and Basford P.A. Funeral Home  
106 East Church St., Frederick, Md. 2170123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. myocardial infarction

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

minutes

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypertension, hypercholesterolemia,  
intermittent atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accidental 6 ☐ Could not be  
determined  
3 ☐ Suicidal 4 ☐ Homicidal28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kathleen W Stern MD

29c. License number

D 32073

29d. Date signed (Month, Day, Year)

February 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Kathleen W. Stern, MD 610 Ninth Avenue, Brunswick, Maryland 21716

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

Dawson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06356

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |   |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
|--|---|--|---|--|--|--|---|--|---|-------------------------|--|----------------------------------|--|---------------------------------|------------|----------------------------------|--|--|---------------------------|-------------|-----------------------------|-------------|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Yunchang Cui</b>   |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>8</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>7:20 AM</b>                                      |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Frederick</b>   |  | 4c. County of Death<br><b>Frederick</b>                                 |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-31-0778</b>   |  | 6. Sex<br><b>15 M 20 F</b>  |  | 7. Age (In yrs. last birthday)<br><b>55</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>July 24, 1941</b>             |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
|  | 9. Birthplace (State or Foreign Country)<br><b>China</b>  |  | 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>Frederick</b>  |  | 10c. City, Town or Location<br><b>Frederick</b>                         |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><b>1 Yes 2 No</b>  |  | 10e. Street and Number<br><b>602 Taney Ave.</b>   |  | 10f. Zip Code<br><b>21702</b>  |  | 10g. Citizen of What Country?<br><b>China</b>                           |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
|  | 11. Marital Status<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><b>1 Yes 2 No</b>  |  | 14. Race - American Indian, Black, White, etc.<br><b>Specify: Asian</b> |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) College (1-4 or 5+)</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>physician</b> |  | 16b. Kind of Business/Industry<br><b>medical research</b>  |  |   |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
|  | 17. Father's Name (First, Middle, Last)<br><b>Jiaten Cui</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Zhifang Sun</b>  |  |   |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Wenxiu Hao (Wife)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>602 Taney Ave., Frederick, Md. 21702</b> |  |   |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
|  | 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory 2/9</b>                     |  | 20c. Location - City or Town, State<br><b>Smithsburg, Md.</b>  |  |   |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |   |  | 22. Name and Address of Facility<br><b>Donald B. Thompson Funeral Home<br/>31 E. Main St., Middletown, Md. 21769</b>                         |  |   |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |  |   |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
|  | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Renal Failure</b></td> <td>Approximate Interval Between Onset and Death<br/><b>2 d</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. <b>hypertension syndrome</b></td> <td><b>2 d</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>c. <b>hepatic failure</b></td> <td><b>14 d</b></td> </tr> <tr> <td>d. <b>multiple hepatoma</b></td> <td><b>9 mo</b></td> </tr> </table> |  |   |  |  |  |   |  | Immediate Cause (Final disease or condition resulting in death) | a. <b>Renal Failure</b> | Approximate Interval Between Onset and Death<br><b>2 d</b> | Due to (or as a consequence of): |  | b. <b>hypertension syndrome</b> | <b>2 d</b> | Due to (or as a consequence of): |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | c. <b>hepatic failure</b> | <b>14 d</b> | d. <b>multiple hepatoma</b> | <b>9 mo</b> |
|  | Immediate Cause (Final disease or condition resulting in death)   | a. <b>Renal Failure</b>  | Approximate Interval Between Onset and Death<br><b>2 d</b>  |  |  |  |   |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
| Due to (or as a consequence of):   |   |  |   |  |  |  |   |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
| b. <b>hypertension syndrome</b>  |   | <b>2 d</b>   |   |  |  |  |   |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
| Due to (or as a consequence of):   |   |  |   |  |  |  |   |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   | c. <b>hepatic failure</b>   | <b>14 d</b>  |   |  |  |  |   |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
|  | d. <b>multiple hepatoma</b>   | <b>9 mo</b>  |   |  |  |  |   |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   |  |  |  |   |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
| 23b. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>   |   |  |   |  |  |  |   |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
| 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>  |   |  |   |  |  |  |   |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b>   |   |  |   |  |  |  |   |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
| 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>  |   |  |   |  |  |  |   |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
| 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>   |   |  |   |  |  |  |   |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
| 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>  |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><b>1 Yes 2 No</b>            |   |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
| 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |   |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
| 29a. Certifier (Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b> |   |  |   |  |  |  |   |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |   |  |   | 29c. License number<br><b>D14626</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2/8/97</b> |   |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DG Rausch 501 W. South St. Frederick MD 21701</b>   |   |  |   |  |  |  |   |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |
| 31. Date filed (Month, Day, Year)<br><b>ED 1 0 1997</b>  |   | 32. Registrar's Signature<br><i>[Signature]</i>  |   |  |  |  |   |  |   |                         |  |                                  |  |                                 |            |                                  |  |  |                           |             |                             |             |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06357

## Certificate of Death

Reg. No.

|   |  |  |   |                                |  |
|---|--|--|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>JOANNE CADIGAN</b>  |  | 2. Date of Death<br>Month <b>2</b> Day <b>17</b> Year <b>97</b>   |                                | 3. Time of Death<br><b>22:45</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>UNIVERSITY OF MARYLAND MEDICAL SYSTEM</b>   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |                                | 4c. County of Death<br><b>BALTIMORE CITY</b>   |
| Funeral<br>Director                           | 5. Social Security Number<br><b>230-84-6954</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>40</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 19, 1956</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>NEW YORK</b>   |                                |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>VIRGINIA</b>  |  | 10b. County<br><b>FAIRFAX</b>   |                                | 10c. City, Town or Location<br><b>ANNANDALE</b>  |
|   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                |  |
|   | 10e. Street and Number<br><b>4504 JOHN TYLER COURT #1</b>  |  | 10f. Zip Code<br><b>22003</b>   |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |   |                                |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CLERK</b>   |                                | 16b. Kind of Business/Industry<br><b>U.S. GOVERNMENT</b>   |
|   | 17. Father's Name (First, Middle, Last)<br><b>JOSEPH F. CADIGAN</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>RITA F. HOLLAND</b>   |                                |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>JOSEPH F. CADIGAN-FATHER</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7455 MADEIRA PL., ANNANDALE, VA 22003</b>   |                                |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>FAIRFAX MEMORIAL PARK</b>  |                                | Date<br><b>2/21/97</b>   |
|   | 20c. Location - City or Town, State<br><b>FAIRFAX, VA</b>  |  |   |                                |  |
| 21. Signature of Funeral Service Licensee<br> |  | 22. Name and Address of Facility<br><b>DEMAINE FUNERAL HOMES, INC.<br/>520 S. WASHINGTON STREET<br/>ALEXANDRIA, VA 22314</b> |   |                                |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. METASTATIC CERVICAL CANCER</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |                                | Approximate Interval Between Onset and Death<br><b>6 MONTHS</b>  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28e. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br><b>M</b>  |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |                                |  |
|   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |
|   | 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |                                |  |
|   | 29b. Signature and title of certifier<br><b>Shana E. Weiss U.D.</b>  |  | 29c. License number<br><b>P10231</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>February 17, 1997</b>  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>SHANA E. WEISS 22 S. GREENE ST. BALTIMORE, MD 21201</b>   |  |   |                                |  |
| State<br>Registrar                            | 31. Date filed (Month, Day, Year)<br><b>FEB 20 1997</b>  |  | 32. Registrar's Signature<br>   |                                |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06358

Amended #10c., 2/20/97, GF, Mont. Co.

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William V. Carpenter

2. Date of Death  
Month Day Year

February 17, 1997

3. Time of Death  
1:25 AM

4a. Facility Name (If not institution, give street and number)

2201 Colston Drive

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-03-5759

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Dec. 31, 1904

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2201 Colston Drive

10f. Zip Code

20910

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Sales &amp; Distribution

16b. Kind of Business/Industry

Wholesale Appliances

17. Father's Name (First, Middle, Last)

Vincent Fielding, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Alice Warren

19a. Informant's Name/Relationship (Type, Print)

R. Bruce Keiner, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1730 Crestwood Drive, N.W. Washington, D.C. 20011

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Parklawn Memorial Park

Date

2/20/97 Rockville, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pulmonary Embolus

Due to (or as a consequence of):

Approximate interval Between Onset and Death

Less Than 8 hrs.

b. Prostate Cancer

Due to (or as a consequence of):

6 Months

c. Bladder Cancer

Due to (or as a consequence of):

6 Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Depression, Metastatic Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 35579

29d. Date signed (Month, Day, Year)

February 19, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Susan J. Miller, M.D. 5530 Wisconsin Avenue #915 Chevy Chase, MD 20815

31. Date filed (Month, Day, Year)

FEB 20 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06359

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Geraldine E.

Carter

2. Date of Death

Month Day Year

February 17, 1997

3. Time of Death

12:40 AM

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

214-36-3046

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

60

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov 26, 1936

9. Birthplace (State or Foreign Country)

Dist Of Col.

Usual Residence of Decedent

10e. State

Md

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8614 11th Ave,

10f. Zip Code

20903

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
Black15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
11th Grade

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Teacher (Ret)

18b. Kind of Business/Industry

New Hampshire Est.  
Elementary School

17. Father's Name (First, Middle, Last)

Isaac Ellison

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Johnson

19a. Informant's Name/Relationship (Type, Print) (Hus)

Mr Melvin Carter Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8614 11th Ave, Silver Spring, Md 20903

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parklawn Memorial Pk2/20/97 Rockville, Md

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

George R. Brandon

22. Name and Address of Facility

Snowden Funeral Home P.A. 20850

246 N. Washington St., Rockville, Md

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Cardiorespiratory Arrest

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

30 minute

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Congestive Cardiac Failure, and

Due to (or as a consequence of):

2 years

c. Chronic Obstructive Lung Disease, and

Due to (or as a consequence of):

2 years

d. Renal Failure

3 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28e. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

M. K. M.D.

29c. License number

D-18895

29d. Date signed (Month, Day, Year)

February 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOBARAK KARIM 7610 CARROLL AVENUE, TAKOMA PARK, MARYLAND 20912

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

John Davidson-Rodell

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06360

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Hsueh-Ming Chen

2. Date of Death  
Month Day Year

February 17, 1997

3. Time of Death

12:20 AM

4e. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

059-32-0497

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 24, 1921

9. Birthplace (State or Foreign Country)

China

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Beltsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4525 Lincoln Avenue

10f. Zip Code

20705

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Asian

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
5+16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Librarian

16b. Kind of Business/Industry

University Library

17. Father's Name (First, Middle, Last)

Unavailable

18. Mother's Name (First, Middle, Maiden Surname)

Unavailable

19a. Informant's Name/Relationship (Type, Print)

Susan Bettina Chen

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4525 Lincoln Avenue, Beltsville, Maryland 20705

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Chesapeake Crematory

Date

2-17-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Carol A. Del...

22. Name and Address of Facility

Rapp Funeral Services, P.A.

933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. Intracerebral Hemorrhage

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mark Parkhurst

29c. License number

024093

29d. Date signed (Month, Day, Year)

2/17/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Parkhurst, MD, 7305 Baltimore Avenue #107, College Park, Maryland 20740

31. Date filed (Month, Day, Year)

32. Registrar's Signature

FEB 18 1997

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06361

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Madalene S. Clark

2. Date of Death

Month  
02Day  
18Year  
97

3. Time of Death

07<sup>35</sup> AM

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

577-50-3099

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 19, 1908

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Berwyn Heights

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8402 57th Avenue

10f. Zip Code

20740

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrative Assistant

16b. Kind of Business/Industry

Internal Revenue Ser.

17. Father's Name (First, Middle, Last)

William

F.

Stroud

18. Mother's Name (First, Middle, Maiden Surname)

Bertha

Ellen Drucilla Elam

19a. Informant's Name/Relationship (Type, Print)

Jeane Ellyne Kidwell (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 2/20/1997

Date

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.

4400 Powder Mill Road Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Urosepsis

Due to (or as a consequence of):

24 hours

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Diabetes

Due to (or as a consequence of):

5 years

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lower Gastrointestinal Blood; History of Myocardial Infarction

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John Marsalis

29c. License number

D25430

29d. Date signed (Month, Day, Year)

2/18/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

John Marsalis 14333 Laurel Bowie Rd # 307 Laurel, MD 20708

31. Date filed (Month, Day, Year)

FEB 21 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06362

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Neal J. Conway, Sr.

2. Date of Death

Month Day Year  
February 17, 1997

3. Time of Death

7:54 AM

4a. Facility Name (If not institution, give street and number)

Mariner Health of Bethesda

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

193-16-9189

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov. 24, 1924

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

5210 Locust Avenue

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give

Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Attorney

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Neal J. Conway

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Keating

19a. Informant's Name/Relationship (Type, Print)

Neal J. Conway, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5210 Locust Avenue, Bethesda, Maryland 20814

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

Feb. 22, 1997

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/

7557 Wisconsin Avenue

Bethesda, Maryland 20814-3501

Bethesda-Chevy

Chase, Inc.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia, Hypothyroidism

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicida☐ Homicida☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D03581

29d. Date signed (Month, Day, Year)

February 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elliot R. Goldstein, M.D. 9410 Old Georgetown Road, Bethesda, Maryland 20814-1700

31. Date filed (Month, Day, Year)

FEB 20 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06363

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marion W. Cullen

2. Date of Death

February 12, 1997

3. Time of Death

1:02 PM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

377-03-0311

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 9, 1903

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3013 Ferndale Street

10f. Zip Code

20895-2752

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Design Engineer

16b. Kind of Business/Industry

U. S. Army

17. Father's Name (First, Middle, Last)

William J. Cullen

18. Mother's Name (First, Middle, Maiden Surname)

Fay Della Paddock

19a. Informant's Name/Relationship (Type, Print)

Joan D. Rinaldi

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13820 Marianna Drive, Rockville, Maryland 20853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate Of Heaven Cemetery

Date

2/15/97

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

William L. Byrd

22. Name and Address of Facility

Francis J. Collins Fuenral Home, Inc.

500 University Blvd. W. Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Ascites and respiratory arrest.

Due to (or as a consequence of):

b.

Liver Cancer.

Due to (or as a consequence of):

c.

Cirrhosis of the Liver

Due to (or as a consequence of):

d.

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Christopher Unger, M.D.

29c. License number

P 15 929

29d. Date signed (Month, Day, Year)

2-12-97 2:05 pm

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Christopher Unger, M.D. 8218 Wisconsin Avenue #208, Bethesda, MD 20814-3169

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Julia Davidson-Rodell

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner




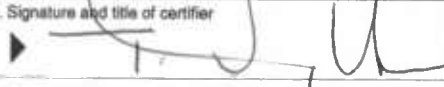
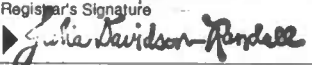
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State of Maryland / Department of Health and Mental Hygiene

97 06364

## Certificate of Death

Reg. No.

|  |  |   |  |  |   |  |
|--|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Charles William CRUICKSHANK</b>   |   | 2. Date of Death<br>Month <b>February</b> Day <b>22</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>10 10 am</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>  |  | 4c. County of Death   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>136-30-5502</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs.   | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 4, 1938</b> |
|  | 9. Birthplace (State or Foreign Country)<br><b>New Jersey</b>  |   |  |  |   |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent  |   | 10a. State<br><b>New Jersey</b>  |  | 10b. County<br><b>Cumberland</b>  |  |
|  | 10c. City, Town or Location<br><b>Fairton</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
|  | 10e. Street and Number<br><b>38 Cedar Lane</b>   |   | 10f. Zip Code<br><b>08302</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1961-64</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1</b> College (1-4 or 5+)                                      |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Pipe Fitter</b>   |  |
|  | 16b. Kind of Business/Industry<br><b>DuPont</b>  |   | 17. Father's Name (First, Middle, Last)<br><b>William T. Cruickshank</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Stella Mick</b>   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Angelina M. Cruickshank - Wife</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 384 - Fairton, NJ 08302</b>                         |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hillcrest Memorial Park</b>   |  | 20c. Location - City or Town, State<br><b>Washington, New Jersey</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>Hicks Home for Funerals, P.A.<br/>103 W. Stockton St., Elkton, MD 21921-5521</b>  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. presumed sepsis</b><br>Due to (or as a consequence of):<br><b>b. immunosuppression</b><br>Due to (or as a consequence of):<br><b>c. non hodgkins lymphoma</b><br>Due to (or as a consequence of):<br><b>d.</b> |   | Approximate Interval Between Onset and Death<br><b>1 week</b><br><b>18 months</b><br><b>3 years</b>  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>polymyalgia rheumatica</b><br><b>profound thrombocytopenia</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 26a. Date of Injury (Month, Day Year)   |  | 26b. Time of Injury<br><b>M</b>  |   |  |
| 26c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26d. Describe how injury occurred   |  | 26e. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>RES - 000</b>                                      |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>February 22, 1997</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ARAS DANYLUK Johns Hopkins Hospital 600 N. Wolfe St. Baltimore MD 4718</b>   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 1997</b>  |  | 32. Registrar's Signature<br>  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 26e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

11. 12. 13. 14. 15. 16. 17. 18. 19. 20.

21. 22. 23. 24. 25. 26. 27. 28. 29. 30.

31. 32. 33. 34. 35. 36. 37. 38. 39. 40.

41. 42. 43. 44. 45. 46. 47. 48. 49. 50.

51. 52. 53. 54. 55. 56. 57. 58. 59. 60.

61. 62. 63. 64. 65. 66. 67. 68. 69. 70.

71. 72. 73. 74. 75. 76. 77. 78. 79. 80.

81. 82. 83. 84. 85. 86. 87. 88. 89. 90.

91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06365

## Certificate of Death

Reg. No.

|                                     |   |  |   |                                |  |
|-------------------------------------|---|--|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Hayes Calvin</b>   |  | 2. Date of Death<br>Month <b>Feb.</b> Day <b>21</b> Year <b>1997</b>  |                                | 3. Time of Death<br><b>6:40PM</b>  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>St. Mary's Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Leonardtwn</b>   |                                | 4c. County of Death<br><b>St. Mary's</b>   |
| Funeral<br>Director                 | 5. Social Security Number<br><b>714-18-1325</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|                                     | 8. Date of Birth<br>Month <b>May</b> Day <b>28</b> Year <b>1923</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>PA.</b>  |                                |  |
| To Be Completed by Funeral Director | Usual Residence of Decedent   |  |   |                                |  |
|                                     | 10a. State<br><b>MD</b>   | 10b. County<br><b>St. Mary's</b>   | 10c. City, Town or Location<br><b>Charlotte Hall</b>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|                                     | 10e. Street and Number<br><b>29449 Charlotte Hall School Rd.</b>  |  | 10f. Zip Code<br><b>20622</b>   |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|                                     | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1942-1946</b>  |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |
|                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>   |                                |  |
|                                     | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Supervisor</b>  |  | 16b. Kind of Business/Industry<br><b>Federal Gov.</b>   |                                |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>Mathew Calvin, Jr.</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen C. Schmidt Calvin</b>   |                                |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carol C. Gettier / Daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9830 Mill Run Dr. Great Falls, VA 22066</b>   |                                |  |
|                                     | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crem.</b>   |                                | 20c. Location - City or Town, State<br><b>2/24/97 Alexandria, VA</b>   |
|                                     | 21. Signature of Funeral Service Licensee<br><b>David C. Clark</b>  |  | 22. Signature of Funeral Home<br><b>AREHART ECHOLS FUNERAL HOME, INC.</b><br>P.O. Box 567 LaPlata, MD 20646   |                                |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Probable Myocardial Infarction</b><br>Due to (or as a consequence of):<br>b. <b>Coronary Artery disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |                                | Approximate Interval Between Onset and Death<br><b>5-6</b>   |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES MELLITUS</b><br><b>PROSTATE CANCER</b>  |  |   |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|                                     | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|                                     | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)<br><b>2-23-97</b>  |                                | 28b. Time of Injury<br><b>M</b>  |
|                                     | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how Injury occurred<br><b>---</b>   |                                |  |
|                                     | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>---</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>---</b>  |                                |  |
|                                     | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |                                |  |
|                                     | 29b. Signature and title of certifier<br><b>William Boyd II</b>   |  | 29c. License number<br><b>D14285</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>2-23-97</b>  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>William Boyd II 25365 Point Lookout Rd. Leonardtown, MD 20650</b>  |  |   |                                |  |
| State<br>Registrar                  | 31. Date filed (Month, Day, Year)<br><b>FEB 24 1997</b>   |  | 32. Registrar's Signature<br><b>John Davidson Randall</b>   |                                |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06366

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

IVA DOUGHTY

2. Date of Death

Month Day Year  
FEBRUARY 14 1997

3. Time of Death

12:25 A.M.

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

CITY

Funeral  
Director

5. Social Security Number

300-22-4335

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
1-22-1928

9. Birthplace (State or Foreign Country)

BOISSEVAIN, VA.

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL CO.

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

105 1/2 FIRST AVE. W.

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10College (1-4or 5+)  
NONE

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NURSING ASSISTANT

16b. Kind of Business/Industry

HOME HOSPICE

17. Father's Name (First, Middle, Last)

ROBERT PARTON

18. Mother's Name (First, Middle, Maiden Surname)

WILLIE MILLER

19a. Informant's Name/Relationship (Type, Print)

ROBERT DOUGHTY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

105 1/2 FIRST AVENUE W. GLEN BURNIE, MD. 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GLEN HAVEN

Date

2-17-97

20c. Location - City or Town, State

GLEN BURNIE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME

1 SECOND AVE. S.W. GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

PNEUMONIA

Approximate Interval Between Onset and Death

3 DAYS

a. Due to (or as a consequence of):

BREAST CANCER

7 YEARS

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending Investigation  
6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

AS 244161436

29d. Date signed (Month, Day, Year)

14<sup>th</sup> February 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. RAGHUVeer SHENOY HARBOR HOSPITAL 3001 S HANOVER STREET BALTIMORE MD 21201

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Davidson

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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State of Maryland / Department of Health and Mental Hygiene

97 06367

## Certificate of Death

Reg. No.

|   |   |   |   |   |  |  |  |                                   |  |  |
|---|---|---|---|---|--|--|--|-----------------------------------|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedant's Name (First, Middle, Last)<br><b>HELEN H. DULIN</b>   |   |   |   | 2. Date of Death<br>Month <b>February</b> Day <b>14</b> Year <b>97</b>   |  |  |                                   | 3. Time of Death<br><b>2:04P</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital at Easton</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>Easton</b>  |  |  |                                   | 4c. County of Death<br><b>Talbot</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-32-6163</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.   |  | If Under 1 Year<br>Months Days                   |                                   | If Under 24 Hrs.<br>Hours Min.   |  |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 16, 1912</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   | Usual Residence of Decedent  |  |  |                                   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Talbot</b>  |   | 10c. City, Town or Location<br><b>Easton</b>   |  |  |                                   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>501 Dutchman's Lane Apt 112</b>  |   |   |   | 10f. Zip Code<br><b>21601</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>      |                                   |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  |  |                                   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>3</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Registered Nurse</b>              |   |  |  | 16b. Kind of Business/Industry<br><b>Medical</b> |                                   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Edward Huntman</b>  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bertha Eberhard</b>  |  |  |                                   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jay E. Dulin (Son)</b>   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>28990 Carter Plain Road, Easton, MD 21601</b>  |  |  |                                   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woodlawn Memorial Park 2/17</b>                                      |   | Date<br><b>Easton, MD</b>  |  | 20c. Location - City or Town, State              |                                   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>M.E. Newnam III C.F.S.P.</b>  |   |   |   | 22. Name and Address of Facility<br><b>Fellows, Helfenbein &amp; Newnam Funeral Home<br/>200 S. Harrison St., Easton, MD 21601</b>   |  |  |                                   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Respiratory failure</b><br>Due to (or as a consequence of)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Chronic pulmonary fibrosis</b><br>Due to (or as a consequence of):<br><b>c. COPD</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |   |   | Approximate Interval Between Onset and Death<br><b>2 wks</b><br><b>25 yrs</b><br><b>15 yrs</b>   |  |  |                                   |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |                                   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                         |  |  |  |                                   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA |   | 26. Place of Death (Check only one)<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |                                   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>Stephen P. Carney</b>   |   | 29c. License number<br><b>01225</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2-15-97</b>                            |  |                                   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Stephen P. Carney, MD, 509 Idlewild Avenue, Easton, MD 21601</b>   |   |   |   |   |  |  |  |                                   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 18 1997</b>   |   | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |   |   |  |  |  |                                   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



## Certificate of Death

Reg. No.

97 06368

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN THOMAS DONOVAN JR.

2. Date of Death

Month

Day

Year

JANUARY 27, 1997

3. Time of Death

6:25P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

338 TERNWING DRIVE

4b. City, Town, or Location of Death

ARNOLD

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

214-84-3152

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

36

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jan 18, 1961

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Arnold

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

338 Ternwing Drive

10f. Zip Code

21012

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

Electric Goods

Supplier

17. Father's Name (First, Middle, Last)

John T. Donovan, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Patricia Coughlan

19a. Informant's Name/Relationship (Type, Print)

Lisa K. Donovan/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

338 Ternwing Dr., Arnold, MD 21012

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory

Date

Jan 31

1997

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home  
495 Gov Ritchie Hwy., Severna Park, MD 21146

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
diagnosis or condition  
resulting in death)

a. Cocaine Intoxication

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☒ Yes ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☒ Yes ☐ No25. Was case referred to medical  
examiner?☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☐ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☒ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JANUARY 28, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

David R Fowler

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

David R Fowler

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 37 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06369

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sophie Florence Degges

2. Date of Death

February 17, 1997

3. Time of Death

11:05 PM

4a. Facility Name (If not institution, give street and number)

Mariner Health of Kensington

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

579-32-6219

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

101 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 10, 1895

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9505 Cable Drive

10f. Zip Code

20895

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WW I

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Abner C. Proctor

18. Mother's Name (First, Middle, Maiden Surname)

May R. Anderson

19a. Informant's Name/Relationship (Type, Print)

James E. Degges, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9505 Cable Drive, Kensington, Maryland 20895

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Feb. 25, 1997

Arlington National Cemetery

Date

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

Raymond Paul

MO0198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/

7557 Wisconsin Avenue

Bethesda, Maryland 20814-3501

Bethesda-Chevy

Chase, Inc.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Approximate

Interval Between

Onset and Death

Immediate Cause (Final

disease or condition

resulting in death)

Urosepsis

a. Due to (or as a consequence of):

Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Hypothyroidism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John J. Merendino, M.D.

29c. License number

D36046

29d. Date signed (Month, Day, Year)

February 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John J. Merendino, M.D. 4701 Randolph Road, Rockville, Maryland 20852

31. Date filed (Month, Day, Year)

FEB 20 1997

32. Registrar's Signature

John J. Merendino

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06370

Amended #8, 2/24/97, JW, Montgomery Cty.

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

COULA LINDA DEMER

2. Date of Death

Month Day Year  
FEBRUARY 17, 1997

3. Time of Death

3:17 PM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578-40-8182

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb. 17, 1997

9. Birthplace (State or Foreign Country)

Greece

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1001 Spring Street #316

10f. Zip Code

20910

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dental Assistant

16b. Kind of Business/Industry

Dental

17. Father's Name (First, Middle, Last)

Stamatis Sapountzis

18. Mother's Name (First, Middle, Maiden Surname)

Maria Voris

19a. Informant's Name/Relationship (Type, Print)

Nickolas Demer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

215 Sportsman Way, Gaithersburg, MD 20878-1150

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

2/21/97

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Michael D. Gibbons

22. Name and Address of Facility

DeVol Funeral Home  
10 East Deer Park Drive  
Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. MULTISYSTEM ORGAN FAILURE

WEEKS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. AORTIC STENOSIS, MITRAL AND TRICUSPID

MONTHS

Due to (or as a consequence of):

REGURGITATION

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HEPATIC COMA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Thomas Miller

29c. License number

D36207

29d. Date signed (Month, Day, Year)

February 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. THOMAS MILITANO 7610 CARROLL AVE SUITE 400 TAKOMA PARK, MD 20912

31. Date filed (Month, Day, Year)

FEB 19 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06371

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DANIEL Patrick DILLON

2. Date of Death  
Month Day Year

FEBRUARY 20, 1997

3. Time of Death

5:20 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

227-54-2079

6. Sex

XX M 20 F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 26, 1944

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland Prince George's

10b. County

10c. City, Town or Location

College Park

10d. Inside City Limits

XX Yes 20 No

10e. Street and Number

3527 Marlborough Way

10f. Zip Code

20740

10g. Citizen of What Country?

United States

11. Marital Status

10 Never Married 20 Married

30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

XX Yes 20 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes XX No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self employed Salesman

16b. Kind of Business/Industry

Retail sales

17. Father's Name (First, Middle, Last)

George William

18. Mother's Name (First, Middle, Maiden Surname)

Dillon

19. Informant's Name/Relationship (Type, Print)

Claudia A. Smallwood (friend)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10

20a. Method of Disposition

10 Burial 20 XX Cremation 30 Removal from State

40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 2/21/1997 Alexandria, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.

4400 Powder Mill Road Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Tamponade

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Coronary artery Bypass

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

XX Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes XX No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes XX No

25. Was case referred to medical examiner?

10 Yes XX No

26. Place of Death (Check only one)

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

Other:

40 Nursing Home

50 Residence

80 Other (Specify)

27. Manner of Death

10 Natural

20 Accident

30 Suicide

40 Homicide

50 Pending Investigation

60 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

10 Yes XX No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

10 Certifying Physician

20 Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Donald V. Borgwardt

29c. License number

28883

29d. Date signed (Month, Day, Year)

2/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. ANJUM QAZI 7610 CARROLL AVE. TAKOMA PARK, MD 20912

31. Date filed (Month, Day, Year)

FEB 21 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



DIMERY, DOROTHY  
83709742 140915

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 06372

|   |  |   |  |   |  |  |  |  |
|---|--|---|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Dorothy V. Dimery</b>                                 |   |  |   | 2. Date of Death<br>Month <b>Feb.</b> Day <b>15</b> , Year <b>1997</b> |  | 3. Time of Death<br><b>7:46 p.</b>                         |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Montgomery General Hospital</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Olney</b>                   |  | 4c. County of Death<br><b>MONTGOMERY</b>                   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>215-20-4199</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.                       |  | 8. Date of Birth (Month, Day, Year)<br><b>May 15, 1921</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Montgomery</b>                                       |  | 10c. City, Town or Location<br><b>Silver Spring</b>        |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>3640 Gleneagle Drive</b>   |  | 10f. Zip Code<br><b>20906</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Nurse</b>   |  | 16b. Kind of Business/Industry<br><b>Health Care</b>  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph M. Johnson</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Frances E. Hammond</b>  |  |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>James E. Johnson (Brother)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3812 Olney-Laytonsville Rd., Olney, MD 20832</b>  |  |   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cem.</b>  |  | 20c. Location - City or Town, State<br><b>2/22/97 Silver Spring, MD</b>   |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>George R. Brundage</i>  |  | 22. Name and Address of Facility<br><b>SNOWDEN FUNERAL HOME, P.A.<br/>ROCKVILLE, MD 20850</b>   |  |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>ACUTE MYOCARDIAL INFARCTION</b><br><br>Due to (or as a consequence of):<br><b>CORONARY ARTERY DISEASE</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>ASTHMA</b> |  | Approximate Interval Between Onset and Death<br><b>HOURS</b><br><b>YEARS</b>  |  |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ASTHMA</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)<br><b>M</b>   |  |  |
| 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  | 29c. License number<br><b>D38457</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 16, 1997</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>N. GUYER MD 1811 PRINCE PHILIP DR, OLNEY MD 20832</b>  |  | 31. Date filed (Month, Day, Year)<br><b>FEB 20 1997</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 06373

## Certificate of Death

Reg. No.

|  |   |   |   |   |   |   |  |  |  |  |  |
|--|---|---|---|---|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Hazel Kelly Driscoll</i>                   |   |   |   | 2. Date of Death<br>Month <i>February</i> Day <i>18</i> Year <i>1997</i>  |   |  |  | 3. Time of Death<br><i>1:00 pm</i>                       |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>10139 Cedar Lane</i> |   |   |   | 4b. City, Town, or Location of Death<br><i>Kensington</i>   |   |  |  | 4c. County of Death<br><i>Montgomery</i>                 |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>215-38-2662</i>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>91</i> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><i>Oct. 6, 1905</i> |  | 9. Birthplace (State or Foreign Country)<br><i>Texas</i> |  |  |
|  | Usual Residence of Decedent   |   |   |   |   |   |  |  |  |  |  |
| 10a. State<br><i>Maryland</i>  |   | 10b. County<br><i>Montgomery</i>  |   | 10c. City, Town or Location<br><i>Kensington</i>  |   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br><i>10139 Cedar Lane</i>  |   |   |   | 10f. Zip Code<br><i>20895</i>   |   |   |  | 10g. Citizen of What Country?<br><i>United States</i>  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>                        |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>4</i> College (1-4or 5+) <i>4</i>  |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Teacher</i>   |   |   |  | 16b. Kind of Business/Industry<br><i>Education</i>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><i>Benjamin Hill Kelly</i>  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Leila Jane Wright</i>   |   |   |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Raymond L. Driscoll/Husband</i>   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>10139 Cedar Lane, Kensington, Maryland 20895</i>  |   |   |  |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Montgomery Crematorium, Inc.</i> |   | Date<br><i>Feb. 19, 1997</i>  |   | 20c. Location - City or Town, State<br><i>Bethesda, Maryland</i>                            |  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Michael J. Kutta</i> M00348  |   |   |   | 22. Name and Address of Facility<br><i>Robert A. Pumphrey Funeral Home/<br/>Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave.<br/>Bethesda, Maryland 20814-3501</i>   |   |   |  |  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>a. Cerebral Vascular Accident</i><br>Due to (or as a consequence of):<br><i>b. Arteriosclerosis</i><br>Due to (or as a consequence of):<br><i>c.</i><br>Due to (or as a consequence of):<br><i>d.</i><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |   |   |   |  |  |  | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>None</i>  |   |   |   |   |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |   |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)<br><i>None</i>   |   | 28b. Time of Injury<br><i>—</i> M   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how Injury occurred<br><i>—</i>  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><i>—</i>   |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><i>—</i>  |   |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |   | 29b. Signature and title of certifier<br><i>John B. Umhou MD</i>  |   |   |  | 29c. License number<br><i>D11024</i>   |  | 29d. Date signed (Month, Day, Year)<br><i>2/18/97</i>  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><i>John B. Umhou MD 8805 Conn. Ave., Chevy Chase, MD. 20815</i>  |   |   |   |   |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>FEB 20 1997</i>  |   |   |   | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |   |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

97 06374

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Sheridan Dinterman

2. Date of Death  
Month Day Year

2 13 97 2145

3. Time of Death

2145

4a. Facility Name (If not institution, give street and number)

Carroll County General Hospital

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

N/A

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

0 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

2/13/97

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10e. State

MD.

10b. County

CARROLL

10c. City, Town or Location

TANEYTOWN

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

58 W. BALTIMORE ST.

10f. Zip Code

21787

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
0

College (1-4or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Infant

16b. Kind of Business/Industry

Infant

17. Father's Name (First, Middle, Last)

DALE LINCOLN DINTERMAN

18. Mother's Name (First, Middle, Maiden Surname)

PENNY A. CUNNINGHAM

19a. Informant's Name/Relationship (Type, Print)

DALE L. DINTERMAN -FATHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

58 W. BALTIMORE ST., TANEYTOWN, MD. 21787

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

CARROLL CREMATION 2/17/97 HAMPSTEAD, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FLETCHER FUNERAL HOME

254 E. MAIN ST., WESTMINSTER, MD. 21157

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Prematurity (23 week gestation)

Approximate  
Interval Between  
Onset and Death

2 hrs.

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28e. Date of Injury

(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Jeffrey S Dome, M.D.

29c. License number

D46149

29d. Date signed (Month, Day, Year)

2/16/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jeffrey S Dome, M.D. Carroll County General Hospital, Westminster, MD 21157

31. Date filed (Month, Day, Year)

FEB 19 1997

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06375

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LESLEY SIMPSON

DEAN

2. Date of Death

Month Day Year  
FEBRUARY 18, 1997

3. Time of Death

9:50 AM

4a. Facility Name (If not institution, give street and number)

5065 MARBURY RUN ROAD

4b. City, Town, or Location of Death

MARBURY

4c. County of Death

CHARLES

Funeral  
Director

5. Social Security Number

577-07-1433

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

OCTOBER 4, 1909

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

MARBURY

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5065 MARBURY RUN ROAD

10f. Zip Code

20658

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

MODEL MAKER

16b. Kind of Business/Industry

DEPARTMENT OF THE NAVY

17. Father's Name (First, Middle, Last)

BERNARD DEAN

18. Mother's Name (First, Middle, Maiden Surname)

ETHEL GATTON

19a. Informant's Name/Relationship (Type, Print)

KENNETH W. DEAN / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 33, MARBURY, MARYLAND 20658

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

TRINITY MEMORIAL GARDENS 2/21/1997 WALDORF, MARYLAND

21. Signature of Funeral Service Licensee

JOHN P. KNISLEY

22. Name and Address of Facility

THE HUNTY FUNERAL HOME, INC.  
P.O. BOX 156, WALDORF, MARYLAND 20604

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. *Parkinson's disease*  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *paraplegia*  
Due to (or as a consequence of):c. *neurogenic bladder*  
Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

THOMAS P. GAGE, M.D.

29c. License number

Maryland D21607

29d. Date signed (Month, Day, Year)

FEBRUARY 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS P. GAGE, M.D., 6-B INDUSTRIAL PARK DR., OLD LINE CENTER, WALDORF, MD 20602

31. Date filed (Month, Day, Year)

FEB 24 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06376

## Certificate of Death

Reg. No.

|  |   |  |   |                                |  |  |  |   |
|--|---|--|---|--------------------------------|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Freida Ann Eakin  |  |   |                                | 2. Date of Death<br>Month Day Year<br>February 5, 1997   |  | 3. Time of Death<br>6:25 P.M.  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br>Frederick Memorial Hospital   |  |   |                                | 4b. City, Town, or Location of Death<br>Frederick  |  | 4c. County of Death<br>Frederick   |   |
| Funeral<br>Director  | 5. Social Security Number<br>578-22-6683  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>78 Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Nov. 5, 1918  |  | 9. Birthplace (State or Foreign Country)<br>West Virginia |
|  | Usual Residence of Decedent   |  |   |                                |  |  |  |   |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland  | 10b. County<br>Washington  | 10c. City, Town or Location<br>Hagerstown   |                                |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |   |
|  | 10e. Street and Number<br>Stonecroft Court  |  |   | 10f. Zip Code<br>21740         |  | 10g. Citizen of What Country?<br>United States   |  |   |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white   |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>8th   |  | College (1-4 or 5+)   |                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker   |  | 16b. Kind of Business/Industry<br>Own Home   |   |
|  | 17. Father's Name (First, Middle, Last)<br>James Garfield Estep   |  |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Laura Whiting   |  |  |   |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>Charles Irvin Eakin, Jr., son   |  |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7319 Eylers Valley Flint Road Thurmont, MD 21788  |  |  |   |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Blue Ridge Cemetery   |                                | 20c. Date<br>2/8/97  |  | 20d. Location - City or Town, State<br>Thurmont, Maryland  |   |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |                                | 22. Name and Address of Facility<br>Stauffer Funeral Homes, P.A.<br>104 East Main Street Thurmont, MD 21788  |  |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. ISCHEMIC BOWEL SYNDROME<br>Due to (or as a consequence of):<br>b. PERFORATION OF SMALL BOWEL<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |  |   |                                |  |  |  |   |
|  | Approximate Interval Between Onset and Death<br>2 weeks<br>Hours  |  |   |                                |  |  |  |   |
| State Registrar  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Atherosclerotic Heart Disease   |  |   |                                |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |
|  |   |  |   |                                |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |
|  |   |  |   |                                |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |                                |  |  |  |   |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |                                | 28b. Time of Injury<br>M   |  | 28c. Injury et Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and Title of Certifier<br>                                      |   | 29c. License number<br>D43091  |  | 29d. Date signed (Month, Day, Year)<br>2-6-97  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>SAEED ZAIDI MD 801 TOLL HOUSE AVE. FREDERICK   |   |  |   |                                |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br>FEB 07 1997   |   |  |   | 32. Registrar's Signature<br>  |  |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06377

## Certificate of Death

Reg. No.

|  |   |  |   |                                |  |
|--|---|--|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>GENEVIEVE ELIZABETH ELLERMAN</b>   |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>15</b> Year <b>1997</b>  |                                | 3. Time of Death<br><b>1910</b>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SHADY GROVE ADVENTIST HOSPITAL</b>   |  | 4b. City, Town, or Location of Death<br><b>ROCKVILLE</b>  |                                | 4c. County of Death<br><b>MONTGOMERY</b>   |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-74-3417</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>Aug 23, 1907</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Indiana</b>  |                                |  |
| To Be Completed by Funeral Director                                  | 10e. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  |                                | 10c. City, Town or Location<br><b>North Potomac</b>  |
|  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                |  |
|  | 10e. Street and Number<br><b>13401 Moran Drive</b>  |  | 10f. Zip Code<br><b>20878</b>   |                                | 10g. Citizen of What Country?<br><b>United States</b>  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |                                |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |                                | 16b. Kind of Business/Industry<br><b>Own Home</b>  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Louis Froelich</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Norma Krug</b>  |                                |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Patricia L. O'Connell, Daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5212 Trailway Drive, Rockville, MD 20853</b>  |                                |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>  |                                | 20c. Location - City or Town, State<br><b>Silver Spring, MD</b>  |
|  | 21. Signature of Funeral Service Licensee<br><i>Sally M. Isui</i>   |  | 22. Name and Address of Facility<br><b>DeVol Funeral Home</b><br><b>10 East Deer Park Drive, Gaithersburg, MD 20877</b>   |                                |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Dilated CARDIOMYOPATHY</b><br>Due to (or as a consequence of):   |  |   |                                | Approximate Interval Between Onset and Death<br><b>4 years</b>   |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>VENTRICULAR TACHYCARDIA</b><br><b>CHRONIC ATRIAL FIBRILLATION</b>   |  |   |                                |  |
|  | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |                                |  |
|  | 23d. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |                                | 28b. Time of injury<br><b>M</b>  |
|  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |                                |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |
| State Registrar  | 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>GREGORY H. FISHER</i>   |                                | 29c. License number<br><b>D26443</b>   |
|  | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 16, 1997</b>   |  |   |                                |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GREGORY H. FISHER 15225 SHADY GROVE ROAD, ROCKVILLE, MARYLAND 20850</b>  |  |   |                                |  |
|  | 31. Date filed (Month, Day, Year)<br><b>FEB 20 1997</b>   |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |                                |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06378

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |  |   |  |  |  |
|---|--|--|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Ada Mae Evans  |  |   |  | 2. Date of Death<br>Month Day Year<br>February 17, 1997   |  |   |  | 3. Time of Death<br>4:55 pm  |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br>Anne Arundel Medical Center  |  |   |  | 4b. City, Town, or Location of Death<br>Annapolis   |  |   |  | 4c. County of Death<br>Anne Arundel  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>226-03-7754   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>79 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Sept 17, 1917  |  | 9. Birthplace (State or Foreign Country)<br>Virginia   |  |
|   | Usual Residence of Decedent  |  |   |  |   |  |   |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br>MD   |  | 10b. County<br>Anne Arundel   |  | 10c. City, Town or Location<br>Severna Park   |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br>607 Cypress Road   |  |   |  | 10f. Zip Code<br>21146  |  | 10g. Citizen of What Country?<br>USA  |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Lodge President  |  |   | 16b. Kind of Business/Industry<br>Machinist Union #1561          |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>William M. Jordan   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ada M  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Hattie E. Brill/sister   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>302 E. Joppa Rd., Apt 405, Towson, MD 21286  |  |   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Meadowridge Cemetery  |  | Date<br>Feb 20 1997   |  | 20c. Location - City or Town, State<br>Elkridge, MD   |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>James E. Barranco</i>  |  |   |  | 22. Name and Address of Facility<br>Barranco & Sons, P.A. Severna Park Funeral Home<br>95 Gov Ritchie Hwy., Severna Park, MD 21146  |  |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. STAPHYLOCOCCAL SEPSIS 2/10/1997<br>Due to (or as a consequence of):<br>b. Cellulitis 2/10/1997<br>Due to (or as a consequence of):<br>c. Chronic venous stasis 1992<br>Due to (or as a consequence of):<br>d. Arthritis YRS |  |   |  |   |  |   |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Hypothyroidism YRS   |  |   |  |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 28. Piece of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28e. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M  |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|   | 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  | 29b. Signature and title of certifier<br><i>Michael Epstein</i>   |  | 29c. License number<br>034426   |  | 29d. Date signed (Month, Day, Year)<br>2-17-97   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>MICHAEL S. EPSTEIN 621 K. St. SE 201 Annapolis MD 20401  |  |   |  |   |  |   |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br>FEB 18 1997   |  |   |  | 32. Registrar's Signature<br><i>John Davidson-Pandell</i>   |  |   |  |  |  |



97 06379

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LEAH R. FELDMAN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 16, 1997</b>  |  | 3. TIME OF DEATH<br><b>6:35 AM</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>154-28-1270</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>98</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 14, 1898</b>                                     |   |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Hebrew Home Of Greater Washington</b>  |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville</b>   |  | 8c. COUNTY OF DEATH<br><b>Montgomery</b>  |   |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>824 Malibu Drive</b>   |  |  |  | 10f. ZIP CODE<br><b>20906</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12 Years</b>  |  | 15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Librarian</b>   |  | 16. KIND OF BUSINESS/INDUSTRY<br><b>Public Library</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Henry Bernstein</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Bessie Harrison</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ruth F. Feldman</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>824 Malibu Drive, Silver Spring, Maryland 20906</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>King David Memorial Garden</b>   |  | 20c. LOCATION — City or Town, State<br><b>Falls Church, Virginia</b>  |  | 20d. DATE<br><b>2/18/1997</b>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Donald C. Stottmeyer</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>STEIN HEBREW MEMORIAL FUNERAL HOME, INC.<br/>232 CARROLL ST, NW, WASHINGTON, DC 20012</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. SMALL BOWEL OBSTRUCTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>b. Unknown Cause</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>d.</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>5 DAYS</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>MULTI-INFARCT DEMENTIA</b>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |   |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Attending Physician</b>  |  | 29c. LICENSE NUMBER<br><b>D18084</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>FEB. 16, 1997</b>                                     |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>D.D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE, MD 20852</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 18 1997</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Rodella</b>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06380

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SR. TERESA M. FURIA, SND

2. Date of Death

Month Day Year  
FEBRUARY 9, 1997

3. Time of Death

1:25 A.M.

4a. Facility Name (If not institution, give street and number)

ST. CATHERINE'S NURSING CENTER

4b. City, Town, or Location of Death

EMMITSBURG

4c. County of Death

FREDERICK

Funeral  
Director

5. Social Security Number

180-16-8504

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

MAY 31, 1922

9. Birthplace (State or Foreign Country)

PHILA., PA.

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

FREDERICK

10c. City, Town or Location

EMMITSBURG

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

331 S. SETON AVE.

10f. Zip Code

21727

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

SISTER OF  
NOTRE DAME

17. Father's Name (First, Middle, Last)

VINCENT FURIA

18. Mother's Name (First, Middle, Maiden Surname)

MARY A. IANNELLA

19a. Informant's Name/Relationship (Type, Print)

SR. MARY ADELE WHITE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

333 S. SETON AVE., EMMITSBURG, MD. 21727

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

SISTERS OF NOTRE DAME 2/12/97

Date

20c. Location - City or Town, State

ELLCOTT CITY, MD.

21. Signature of Funeral Service Licensee

John M. Skiles

22. Name and Address of Facility

SKILES FUNERAL HOME  
210 W. MAIN ST., EMMITSBURG, MD. 2172723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Ischemic Cardiomyopathy

Due to (or as a consequence of):

Coronary Artery Disease and

Due to (or as a consequence of):

Hypertension

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

48 hrs

7 10 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Rheumatoid Arthritis

Chronic Obstructive Lung Disease

Cooley's Anemia / Parkinson

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner as stated.

29b. Signature and title of certifier

Alan Carroll

29c. License number

D18705

29d. Date signed (Month, Day, Year)

FEBRUARY 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALAN CARROLL, M.D., 310 S. SETON AVE., EMMITSBURG, MD. 21727

31. Date filed (Month, Day, Year)

FEB 10 1997

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06381

## Certificate of Death

Reg. No.

|  |  |   |  |  |  |  |  |   |
|--|--|---|--|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>IRVIN E Freedman</b>                          |   |  |  | 2. Date of Death<br>Month <b>2</b> Day <b>15</b> Year <b>97</b>  |  | 3. Time of Death<br><b>7:47</b>  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Holy Cross Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Silver Spring Md.</b> |  | 4c. County of Death<br><b>Montg.</b>   |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>467-10-3548</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.   | If Under 1 Year<br>Months Days                                   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>03/20/1913</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>TEXAS</b>  |
|  | Usual Residence of Decedent  |   |  |  |  |  |  |   |
| 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>MONTGOMERY</b>  |  | 10c. City, Town or Location<br><b>SILVER SPRING</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>1 EASTMOOR DRIVE</b>  |  |   |  | 10f. Zip Code<br><b>20901</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ARCHITECT ENGINEER</b>   |  | 16b. Kind of Business/Industry<br><b>STORE DESIGNER</b>  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>JACOB FREEDMAN</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ESTHER MILLER</b>  |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>SALLY FREEDMAN (WIFE)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1 EASTMOOR DRIVE SILVER SPRING, MARYLAND 20901</b>                                       |  |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>JUDEAN MEMORIAL GARDENS</b>  |  | 20c. Location - City or Town, State<br><b>2/18/97 OLNEY, MARYLAND</b>  |  |  |  |   |
| 21. Signature of Funeral Service Licensee<br><i>Frank A. Stone</i>   |  |   |  | 22. Name and Address of Facility<br><b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br/>1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852</b>   |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cardiac Arrest</b><br>Due to (or as a consequence of):<br>b. <b>Wremia</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>Sudden</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ureteral Cancer</b><br><b>renal failure</b>   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |
|  |  |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  |  |   |
| 29b. Signature and title of certifier<br><b>Edward C. Kuten M.D.</b>   |  |   |  | 29c. License number<br><b>D51455</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2-15-97</b>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>15225 Shady Grove Rd. Rockville Md. 20850</b>   |  |   |  |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 19 1997</b>  |  |   |  | 32. Registrar's Signature<br><i>Sha Davidson-Randall</i>   |  |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06382

Reg. No.

|   |   |   |   |   |  |  |  |   |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
|---|---|---|---|---|--|--|--|---|--|--|---|----|----------------------------|---|----|------------------|-------------|----|--|--------------|----|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Lillian Flohr</b>  |   |   |   | 2. Date of Death<br>Month <b>February</b> Day <b>18</b> Year <b>1997</b>   |  |  |   | 3. Time of Death<br><b>7:49 p.m.</b>   |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>Frederick</b>   |  |  |   | 4c. County of Death<br><b>Frederick</b>  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>215-24-4464 A</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 18 1905</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
|   | Usual Residence of Decedent   |   |   |   |  |  |  |   |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Howard</b>  |   | 10c. City, Town or Location<br><b>Lisbon</b>   |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
|   | 10e. Street and Number<br><b>16037 Frederick Road</b>   |   |   |   | 10f. Zip Code<br><b>21765</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                |   |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>   |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  |  | 16b. Kind of Business/Industry<br><b>Domestic</b>                       |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>George E. Beasman</b>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Minnie V. Trayer</b>   |  |  |   |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carrie L. Dell (daughter)</b>  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12211 Frederick Rd. Ellicott City MD 21043</b>   |  |  |   |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oak Grove Cemetery</b>   |   | Date<br><b>2/22/97</b>   |  | 20c. Location - City or Town, State<br><b>Glenwood, MD</b> |   |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Brian P. Hays</i>   |   |   |   | 22. Name and Address of Facility<br><b>Haight Funeral Home<br/>P.O. Box 195 Sykesville MD 21784</b>  |  |  |   |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |   |  |  |  |   |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
|   | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><i>Respiratory Failure</i></td> <td>Approximate Interval Between Onset and Death<br/><i>Days</i></td> </tr> <tr> <td>b.</td> <td><i>Pneumonia</i></td> <td><i>Days</i></td> </tr> <tr> <td>c.</td> <td><i>Chronic obstructive pulmonary disease</i></td> <td><i>Years</i></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> |   |   |   |  |  |  |   |  |  | Immediate Cause (Final disease or condition resulting in death) | a. | <i>Respiratory Failure</i> | Approximate Interval Between Onset and Death<br><i>Days</i> | b. | <i>Pneumonia</i> | <i>Days</i> | c. | <i>Chronic obstructive pulmonary disease</i> | <i>Years</i> | d. |  |
| Immediate Cause (Final disease or condition resulting in death)   | a.  | <i>Respiratory Failure</i>                      | Approximate Interval Between Onset and Death<br><i>Days</i>   |   |  |  |  |   |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
|   | b.  | <i>Pneumonia</i>                                | <i>Days</i>   |   |  |  |  |   |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
|   | c.  | <i>Chronic obstructive pulmonary disease</i>    | <i>Years</i>  |   |  |  |  |   |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
|   | d.  |   |   |   |  |  |  |   |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Degenerative Joint Disease</i>   |   |   |   |   |  |  |  |   |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |   |   |  |  |  |   |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   |   |  |  |  |   |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |   |  |  |  |   |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   |   |  |  |  |   |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |   |   |   |  |  |  |   |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide   |   |   |   |   |  |  |  |   |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
| 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>                 |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |   |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |   |  |  |  |   |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |   |   |   | 29c. License number<br><b>026499</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2-19-97</b>                        |  |   |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>4 Colwell Drive Mt Airy Md 21771</b>   |   |   |   |   |  |  |  |   |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 20 1997</b>   |   | 32. Registrar's Signature<br><i>[Signature]</i> |   |   |  |  |  |   |  |  |   |    |                            |   |    |                  |             |    |  |              |    |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I, II, 27 per MEO G-745 3/21/97 <sup>Feb</sup> Certificate of Death

Reg. No.

97 06383

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

DANIEL GRIFFIN

2. Date of Death  
Month Day Year  
FEB. 12, 19973. Time of Death  
1810 P

4a. Facility Name (If not institution, give street and number)

300 E. MADISON ST.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

047-32-6095

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

03/31/1943

9. Birthplace (State or Foreign  
Country)

Connecticut

Usual Residence of Decedent

10e. State

MD

10b. County

N/A

10c. City, Town or Location

BROOKLYN

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

301 CHESAPEAKE AVE.

10f. Zip Code

21225

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever In U.S.  
Armed Forces?1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1961-  
196613. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
NONE16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

SECURITY

16b. Kind of Business/Industry

ST. AGNES HOSPITAL

17. Father's Name (First, Middle, Last)

MICHAEL TIMOTHY GRIFFIN

18. Mother's Name (First, Middle, Maiden Surname)

SHEILA BUCKLEY

19e. Informant's Name/Relationship (Type, Print)

ANGELINA E. GRIFFIN (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

301 CHESAPEAKE AVE. BROOKLYN, MD. 21225

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

GLEN HAVEN MEMORIAL PARK

Date

2-17-97

20c. Location - City or Town, State

GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME

1 SECOND AVE., S.W. GLEN BURNIE, MARYLAND 21061

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

CIRRHOSIS

e.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) JAIL

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28e. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

FEB. 13, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

David R Fowler

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

David R. Fowler

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06384

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frank Anthony GRIEB

2. Date of Death

Month Day Year  
Feb. 12, 1997

3. Time of Death

5:04 PM

4a. Facility Name (If not institution, give street and number)

Garrett County Memorial Hospital

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

Funeral  
Director

5. Social Security Number

142-18-0984

6. Sex

15 M 2 F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 15, 1925

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

MD

10b. County

Garrett

10c. City, Town or Location

Oakland

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

P.O. Box 452

10f. Zip Code

21550

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 Yes 2 No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Line Mechanic

16b. Kind of Business/Industry

Pharmaceutical Manuf.

17. Father's Name (First, Middle, Last)

William

Grieb

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice

Martin

19a. Informant's Name/Relationship (Type, Print)

Ruth I. Grieb

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 452, Oakland, Maryland 21550

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Omega Crematory

Date

2/18

20c. Location - City or Town, State

Morgantown, WV

21. Signature of Funeral Service Licensee

Bridget A. Stead

22. Name and Address of Facility

Stewart Funeral Home  
32 S. Second St., Oakland, MD 21550Physician  
/Medical  
Examiner23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Cardiac Shock

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

24 hrs.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Valvular Heart Disease

Due to (or as a consequence of):

10 yrs.

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy  
performed?

1 Yes 2 No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 Yes 2 No

25. Was case referred to medical  
examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending  
2 Accident investigation  
3 Suicide 6 Could not be  
4 Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dr. Robert Goralski

29c. License number

D23979

29d. Date signed (Month, Day, Year)

2/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Robert Goralski, MD 311 N. Fourth St., Oakland, Maryland 21550

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
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To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06385

|  |  |  |   |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br>HARRY BRATTE GRAHAM  |  |   |  | 2. Date of Death<br>Month Day Year<br>FEBRUARY 26, 1997  |  | 3. Time of Death<br>07:40 AM                                     |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>SHADY GROVE ADVENTIST HOSPITAL   |  |   |  | 4b. City, Town, or Location of Death<br>ROCKVILLE  |  | 4c. County of Death<br>MONTGOMERY                                |  |
| Funeral<br>Director                              | 5. Social Security Number<br>403 26 0136   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>74 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>JUNE 29, 1922             |  |
|  | 9. Birthplace (State or Foreign Country)<br>VIRGINIA   |  | 10a. State<br>MARYLAND  |  | 10b. County<br>MONTGOMERY  |  | 10c. City, Town or Location<br>LAYTONSVILLE                      |  |
| To Be Completed by<br>Funeral Director           | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br>21408 LAYTONSVILLE ROAD   |  | 10f. Zip Code<br>20882   |  | 10g. Citizen of What Country?<br>UNITED STATES                   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WWII  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE |  |
| To Be Completed by<br>Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) 0  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>DISTRICT MANAGER   |  | 16b. Kind of Business/Industry<br>LIFE INSURANCE   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>ROBERT LEE GRAHAM   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>LILLIE MAE SMITH   |  | 19a. Informant's Name/Relationship (Type, Print)<br>JANICE ANN FITTS, DAUGHTER   |  |  |  |
| To Be Completed by<br>Physician/Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>21408 LAYTONSVILLE ROAD, LAYTONSVILLE, MD. 20882  |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>MT. MORIAH CHURCH CEM. 3/1/97  |  | 20c. Location - City or Town, State<br>JONESVILLE, VIRGINIA      |  |
|  | 21. Signature of Funeral Service Licensee<br>Muriel H. Barber  |  | 22. Name and Address of Facility<br>MURIEL H. BARBER FUNERAL HOME<br>P.O. BOX 5038, LAYTONSVILLE, MD. 20882   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>a. ventricular arrhythmia<br>Due to (or as a consequence of):<br>b. congestive heart failure<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br>Min's<br>yrs. |  |  |  |
| To Be Completed by<br>Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  |
| To Be Completed by<br>Physician/Medical Examiner | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred                                |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |  |
| To Be Completed by<br>Physician/Medical Examiner | 29b. Signature and title of certifier<br>Steven B. Sevass  |  | 29c. License number<br>D29643   |  | 29d. Date signed (Month, Day, Year)<br>February 26, 1997   |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>9901 Medical Center Drive Rockville, Maryland 20850  |  | 31. Date filed (Month, Day, Year)<br>MAR 05 1997  |  | 32. Registrar's Signature<br>John Davidson-Randall   |  |  |  |

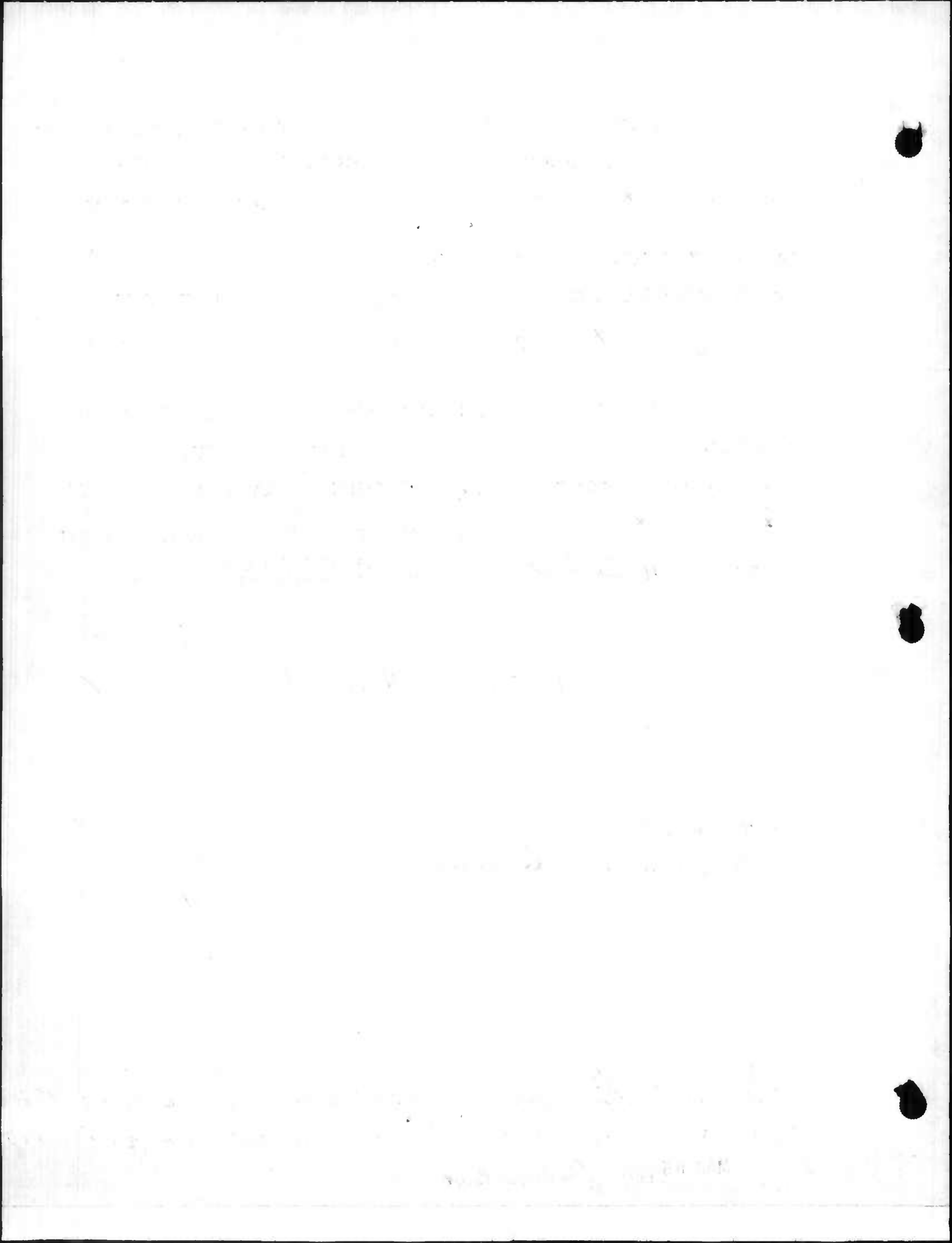
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06386

## Certificate of Death

Reg. No.

|   |   |  |   |   |  |  |  |  |  |  |  |  |  |
|---|---|--|---|---|--|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Lucy Anna Galpin  |  |   |   | 2. Date of Death<br>Month Day Year<br>Feb. 11, 1997  |  | 3. Time of Death<br>9:35 P.M.  |  |  |  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>12601 West Oaks Drive   |  |   |   | 4b. City, Town, or Location of Death<br>Mt. Airy   |  | 4c. County of Death<br>Frederick   |  |  |  |  |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>230-48-7967  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>86 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.             | 8. Date of Birth (Month, Day, Year)<br>June 17, 1910                                 |  | 9. Birthplace (State or Foreign Country)<br>Maryland |  |  |  |  |
|   | Usual Residence of Decedent   |  |   |   |  |  |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br>Virginia  |  | 10b. County<br>Arlington  |   | 10c. City, Town or Location<br>Arlington   |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |  |  |
|   | 10e. Street and Number<br>2307 North Nottingham Street  |  |   |   | 10f. Zip Code<br>22205   |  | 10g. Citizen of What Country?<br>United States                                       |  |  |  |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |  |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (14 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Housewife                                |   |  | 16b. Kind of Business/Industry<br>Own Home |  |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br>Howard Beckett   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Sarah Hall  |  |  |  |  |  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Robert Galpin, son  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4515 North 26th Street Arlington, Virginia 22207  |  |  |  |  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>National Memorial Park  |   | 20c. Location - City or Town, State<br>2/14/97 Falls Church, Virginia  |  |  |  |  |  |  |  |  |
|   | 21. Signature of Funeral Service Licensee   |  | 22. Name and Address of Facility<br>Stauffer funeral Homes, P.A.<br>1621 Opossumtown Pike Frederick, MD 21702   |   |  |  |  |  |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. ANEURYSMAL RUPTURE / DISSECTION DAYS<br>Due to (or as a consequence of):<br>b. THORACO-ABDOMINAL AORTIC ANEURYSM YEARS<br>Due to (or as a consequence of):<br>c. ATHEROSCLEROTIC VASCULAR DISEASE YEARS<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |  |  |  | Approximate Interval Between Onset and Death   |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |   |  |  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                    |  |  |  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |  |  |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |  |  |  |  |  | 29c. License number<br>D-40201   |  | 29d. Date signed (Month, Day, Year)<br>Feb. 12, 1997 |  |
|   | 29b. Signature and title of certifier<br>Farzad Assar, M.D.   |  |   |   |  |  |  |  |  |  |  |  |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>FARZAD ASSAR, M.D. 1502 S. MAIN ST. MTAIRY, MD 21771  |  |   |   |  |  |  |  |  |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br>FEB 12 1997  |  | 32. Registrar's Signature<br>Julia Davis-Randall  |   |  |  |  |  |  |  |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06387

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clara

Ann

Ghiloni

2. Date of Death

February 13, 1997

3. Time of Death

11:00P.

4a. Facility Name (If not institution, give street and number)

Hillhaven Nursing Home

4b. City, Town, or Location of Death

Adelphi

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

577-18-7739

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 2, 1911

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Adelphi

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

3210 Powder Mill Road

10f. Zip Code

20783

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Eastman Kodak  
Quality Control

17. Father's Name (First, Middle, Last)

Carlo G. Ghiloni

18. Mother's Name (First, Middle, Maiden Surname)

Sylvia M. Vanni

19a. Informant's Name/Relationship (Type, Print)

June Larner (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4501 Tonquil Street Beltsville, Maryland 20705

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery 2/17/1997

Date

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

Brad V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.  
4400 Powder Mill Road Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

URO SEPSIS

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e.

b.

c.

d.

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 WEEKS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

D25009

29d. Date signed (Month, Day, Year)

February 14, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Pamela Mulshine, M.D. 11251 Lockwood Drive, Silver Spring, Maryland 20901

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06388

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |   |
|---|--|--|---|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Jerry Eugene CRUMMITT</b>   |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>7</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>6:50 AM</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Northampton Manor Nursing Home</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Frederick</b>   |  | 4c. County of Death<br><b>Frederick</b>  |   |
| Funeral<br>Director                           | 5. Social Security Number<br><b>219-34-5514</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>July 8, 1938</b>   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|   | Usual Residence of Decedent  |  |   |  |  |  |  |   |
| To Be Completed by Funeral Director           | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Frederick</b>   |  | 10c. City, Town or Location<br><b>Frederick</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |
|   | 10e. Street and Number<br><b>203 East Sixth Street</b>   |  |   |  | 10f. Zip Code<br><b>21701</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>   |  | 16b. Kind of Business/Industry<br><b>General Contractor</b>  |  |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>James Leon CRUMMITT</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary SMITH</b>   |  |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Pauline F. Keeney, Sister</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5901 Broadrun Road, Jefferson, Maryland 21755</b>  |  |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mount Olivet Cemetery, Frederick, Maryland</b>   |  | 20c. Location - City or Town, State<br><b>Frederick, Maryland</b>  |  |  |   |
|   | 21. Signature of Funeral Service Licensee<br><b>Richard E. Hraf</b> M00255   |  | 22. Name and Address of Facility<br><b>Keeney and Basford P.A. Funeral Home<br/>106 East Church St., Frederick, Md. 21701</b>   |  |  |  |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Squamous cell carcinoma of mouth 1 year</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |   |  |  |  |  |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |
|   |  |  |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|   |  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
|   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  |   |
|   | 29b. Signature and title of certifier<br><b>W. Allgaier</b>  |  | 29c. License number<br><b>D 16675</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>February 7, 1997</b>   |  |  |   |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Wayne Allgaier MD 610 Ninth Avenue, Brunswick, Maryland 21716</b>   |  |   |  |  |  |  |   |
|   | 31. Date filed (Month, Day, Year)<br><b>FEB 10 1997</b>  |  | 32. Registrar's Signature<br><b>John Davidson-Randall</b>   |  |  |  |  |   |
|   | State Registrar  |  |   |  |  |  |  |   |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

X

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06389

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alfred

Hood

2. Date of Death

February 15, 1997

3. Time of Death

7:40 A.M.

4a. Facility Name (If not institution, give street and number)

Wilson Health Care Center

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery County

Funeral  
Director

5. Social Security Number

278-07-1732

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

95

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

March 5, 1901

9. Birthplace (State or Foreign Country)

England

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

301 Russell Avenue

10f. Zip Code

20879

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

Building Trades

17. Father's Name (First, Middle, Last)

Matthew Hood

18. Mother's Name (First, Middle, Maiden Surname)

Mary Anne Yeoman

19a. Informant's Name/Relationship (Type, Print)

Robert H. Hood Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10025 Dellcastle Road, Gaithersburg, MD 20879

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oakwood Cemetery

Date

Feb. 18, 1997 Warren, Ohio

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

#M00690

22. Name and Address of Facility

McFarland &amp; Son Funeral Home

271 North Park Ave., Warren, Ohio 44482

23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Stroke

Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Alzheimer's Disease

Months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cancer Prostate, Congestive Heart

Failure, Patient's Desire, Kidney Stone

Alcohol Consumption

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D27301

29d. Date signed (Month, Day, Year)

February 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Douglas Shumaker, M.D. 615 West Montgomery Avenue, Rockville, Maryland

31. Date filed (Month, Day, Year)

FEB 20 1997

32. Registrar's Signature

John Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06390

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Myrtle Virginia HARVEY

2. Date of Death

February 21, 1997

3. Time of Death

7:19 AM

4a. Facility Name (If not institution, give street and number)

Garrett County Memorial Hospital

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

Funeral  
Director

5. Social Security Number

214-34-1863

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Apr. 3, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Garrett

10c. City, Town or Location

Oakland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2015 Underwood Road

10f. Zip Code

21550

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Calvin ----- Collins

18. Mother's Name (First, Middle, Maiden Summa)

Pheobie Jane Savage

19a. Informant's Name/Relationship (Type, Print)

Donna Ahern/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2015 Underwood Road, Oakland, Maryland 21550

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Garrett Co. mem. Gardens

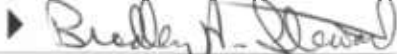
Date

2/23

20c. Location - City or Town, State

Oakland, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Stewart Funeral Home

32 S. Second st., Oakland, MD 21550

23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Pneumonia

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

3 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D23979

29d. Date signed (Month, Day, Year)

2/21/97

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Dr. Robert Goralski, MD 311 N. Fourth St., Oakland, MD 21550

31. Date filed (Month, Day, Year)

FEB 21 1997

32. Registrar's Signature



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06391

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DONALD CHARLES HACKEY

2. Date of Death

FEB. 16 1997

Day

Year

3. Time of Death

11:50 AM

4a. Facility Name (If not institution, give street and number)

WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death

HAGERSTOWN

4c. County of Death

WASHINGTON

Funeral  
Director

5. Social Security Number

219-44-4173

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

APR. 29, 1943

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

WASHINGTON

10c. City, Town or Location

HAGERSTOWN

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1045 EAST NOLAN DRIVE

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
7 TH GRADE

College (1-4 or 5+)

BAKER

17. Father's Name (First, Middle, Last)

PAUL F. HACKEY

18. Mother's Name (First, Middle, Maiden Summa)

DAISY BELL WHITE

19a. Informant's Name/Relationship (Type, Print)

CAROLYN SUMMERS sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1045 EAST NOLAN DRIVE HAGERSTOWN MD 217 40

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FAIRVIEW CEM.

Date

FEB. 20, 97

20c. Location - City or Town, State

FREDERICK, M D.

21. Signature of Funeral Service Licenses

► Gary L. Rollins

22. Name and Address of Facility

GARY L. ROLLINS FUNERAL HOME 21701  
100 WET ALL SAINTS ST FREDERICK, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

b. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

5 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End stage kidney disease; HYPERTENSION.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► Ali Raza MD

29c. License number

D22313

29d. Date signed (Month, Day, Year)

2-16-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALI RAZA MD, WASHINGTON COUNTY HOSPITAL

31. Date filed (Month, Day, Year)

FEB 28 1997

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06392

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LAURA ELIZABETH HAHN

2. Date of Death

Month Day Year  
FEBRUARY 12, 1997

3. Time of Death

4:50 AM

4a. Facility Name (If not institution, give street and number)

Carroll County General Hospital

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

215-03-6138

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 15, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Mt. Airy

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

207 East Ridgeville Blvd.

10f. Zip Code

21771

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own home

17. Father's Name (First, Middle, Last)

Eugene H. Dixon

18. Mother's Name (First, Middle, Maiden Surname)

Effie J. Dixon

19a. Informant's Name/Relationship (Type, Print)

Charles E. Main - Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5104 Woodbine Road, Woodbine, Md. 21797

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Pine Grove

Date

2/15/97

20c. Location - City or Town, State

Mt. Airy, Md.

21. Signature of Funeral Service Licensee

Olin L. Molesworth

22. Name and Address of Facility

Olin L. Molesworth, P.A., Funeral Home  
26401 Ridge Rd., Damascus, Md. 2087223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 weeks

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. RENAL FAILURE

Due to (or as a consequence of):

2 weeks

c. DIVERTICULITIS

Due to (or as a consequence of):

3 weeks

d. CONGESTIVE HEART FAILURE

3 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CEREBROVASCULAR ACCIDENT

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Don H. Schaeffer MD

29c. License number

D28221

29d. Date signed (Month, Day, Year)

February 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAN H. SCHAEFFER, MD 200 MEMORIAL AVENUE WESTMINSTER MARYLAND

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

John Davidson-Randall

21157

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first of these is the fact that the  
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06393

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Donald Grant HARRINGTON

2. Date of Death

February 14, 1997

3. Time of Death

08:30am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

8196 Honey Clover Court

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

456-62-0483

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

56

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 1, 1940

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

8196 Honey Clover Court

10f. Zip Code

21702

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

1966 to 1993

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Research Veterinarian

16b. Kind of Business/Industry

U. S. Army

17. Father's Name (First, Middle, Last)

Clyde G. Harrington

18. Mother's Name (First, Middle, Maiden Surname)

Martha Mary Ann Hobbs

19a. Informant's Name/Relationship (Type, Print)

Marilyn V. Harrington/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8196 Honey Clover Court, Frederick, Md. 21702

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory

Date

February 15, 1997

20c. Location - City or Town, State

Smithsburg, Md.

21. Signature of Funeral Service Licensee

 M00021

22. Name and Address of Facility

Keeney and Basford Funeral Home

106 East church Street, Frederick, Maryland 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. Recurrent Small Cell Lung Cancer

14 months

Due to (or as a consequence of):

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOAOther: ☒ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D35164

29d. Date signed (Month, Day, Year)

February 14, 1997

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Andrew Zarick, Jr., M.D., 1080 West Patrick Street, Frederick, Maryland 21702

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

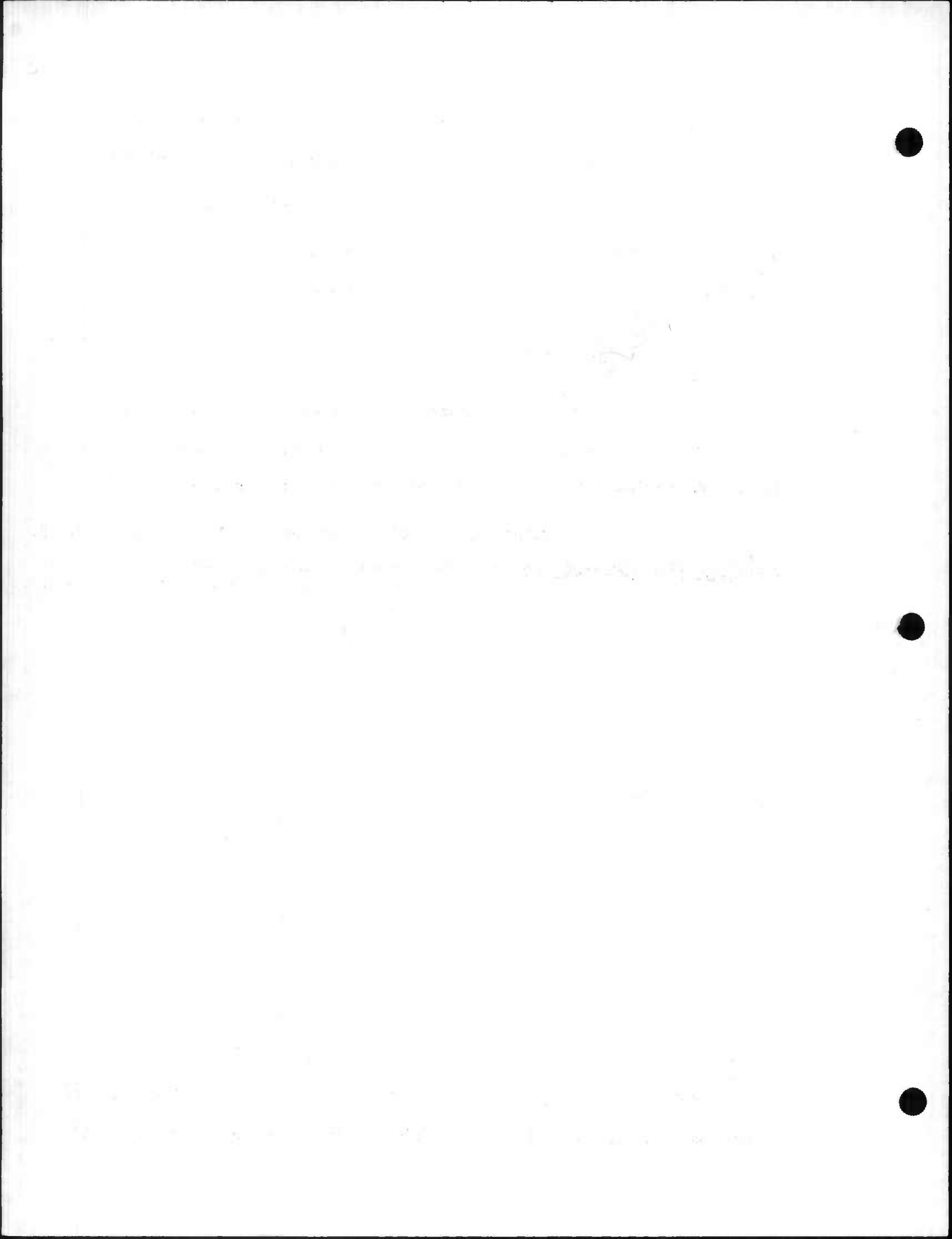
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06394

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

THELMA KOONTZ HANDLEY

2. Date of Death

Month Day Year  
FEBRUARY 12, 1997

3. Time of Death

2:10 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

217-12-1783

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Mar. 31, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1494 West Tenth Street

10f. Zip Code

21701

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Board of Education

17. Father's Name (First, Middle, Last)

Ralph O. Koontz

18. Mother's Name (First, Middle, Maiden Surname)

Amanda Taylor Koontz

19a. Informant's Name/Relationship (Type, Print)

Charles R. Handley

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1504 West 9th Street

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Lukes Church Cemetery

Date

2/17/97

20c. Location - City or Town, State

Feagaville, Maryland

21. Signature of Funeral Service Licensee

Ryan M. Burger

22. Name and Address of Facility

Stauffer Funeral Home  
1621 Opossumtown Pike, Frederick, MD 21702

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute hemorrhagic stroke

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Ali J. Afrookteh MD

29c. License number

D 35183

29d. Date signed (Month, Day, Year)

2/12/97

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Ali J. Afrookteh MD 300 W 9th St Frederick, MD

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Sandra Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06395

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CLYFFETON WILLIAM HILL JR.

2. Date of Death

February 9, 1997

3. Time of Death

12:55 PM

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

017-14-3372

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

June 23, 1917 Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

709 Fairview Avenue

10f. Zip Code

21701

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chemical Engineer

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Clyffeton William Hill, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Marjorie Higgins

19a. Informant's Name/Relationship (Type, Print)

Willie Dennis Hill, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

709 Fairview Avenue Frederick, Maryland 21701

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resthaven Mem Gardens

Date

2/13/97

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stauffer Funeral Homes, P.A.  
1621 Opossumtown Pike Frederick, MD 21702

23a. Part I. Enter the disease or complication which caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pulmonary edema

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Heart Failure

Due to (or as a consequence of):

Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary Hypertension

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

027544

29d. Date signed (Month, Day, Year)

2/9/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. John A. Vitarello MD 310 W. Ninth St. Frederick, MD 21701

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06396

## Certificate of Death

Reg. No.

|   |  |                     |   |   |  |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
|---|--|---------------------|---|---|--|--|---|--|---|----|-----------------------|---|----|---------------------|----|-----------------|----|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Charles C. Hunter</b>   |                     |   |   | 2. Date of Death<br>Month Day Year<br><b>February 6, 1997</b>  |  | 3. Time of Death<br><b>9:35 P.M.</b>                                    |  |   |    |                       |   |    |                     |    |                 |    |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Frederick Memorial Hospital</b>   |                     |   |   | 4b. City, Town, or Location of Death<br><b>Frederick</b>   |  | 4c. County of Death<br><b>Frederick</b>                                 |  |   |    |                       |   |    |                     |    |                 |    |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>579-10-6762</b>  |                     | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>July 1, 1913</b>              |  |   |    |                       |   |    |                     |    |                 |    |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |                     | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Frederick</b>  |  | 10c. City, Town or Location<br><b>Mount Airy</b>                        |  |   |    |                       |   |    |                     |    |                 |    |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                     | 10e. Street and Number<br><b>12915 Penn Shop Road</b>   |   | 10f. Zip Code<br><b>21771</b>  |  | 10g. Citizen of What Country?<br><b>American</b>                        |  |   |    |                       |   |    |                     |    |                 |    |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |                     | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |    |                       |   |    |                     |    |                 |    |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b><br>Collega (1-4or 5+)  |                     | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Carpenter</b>                     |   | 16b. Kind of Business/Industry<br><b>Carpentry</b>   |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Richard L. Hunter</b>  |                     |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Beulah McCrossin</b>   |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Nettie E. Hunter - Wife</b>   |                     |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12915 Penn Shop Road, Mount Airy, Maryland 21771</b>                                     |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                     | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Potomac Methodist Cemetery 2/11</b>                                  |   | 20c. Location - City or Town, State<br><b>Potomac, Maryland</b>  |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Thom L. Williams</b>   |                     |   |   | 22. Name and Address of Facility<br><b>Olin L. Molesworth, P.A., Funeral Home<br/>26401 Ridge Road, Damascus, Maryland 20872</b>   |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |                     |   |   |  |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
|   | <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>CARDIOMYOPATHY</b></td> <td rowspan="4">           Due to (or as a consequence of):<br/><br/>           years<br/><br/>           years<br/><br/>           years         </td> </tr> <tr> <td>b.</td> <td><b>HYPERTENSION</b></td> </tr> <tr> <td>c.</td> <td><b>DIABETES</b></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |                     |   |   |  |  |   |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <b>CARDIOMYOPATHY</b> | Due to (or as a consequence of):<br><br>years<br><br>years<br><br>years | b. | <b>HYPERTENSION</b> | c. | <b>DIABETES</b> | d. |  |
|   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a.                  | <b>CARDIOMYOPATHY</b>   | Due to (or as a consequence of):<br><br>years<br><br>years<br><br>years |  |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
| b.  |  | <b>HYPERTENSION</b> |   |   |  |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
| c.  |  | <b>DIABETES</b>     |   |   |  |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
| d.  |  |                     |   |   |  |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ACUTE RENAL FAILURE</b>  |  |                     |   |   |  |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |                     |   |   |  |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                     |   |   |  |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                     |   |   |  |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                     |   |   |  |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |                     |   |   |  |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |                     |   |   |  |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
| 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                     |   |   |  |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
| 28d. Describe how injury occurred<br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |                     |   |   |  |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                     |   |   |  |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
| 29b. Signature and title of certifier<br><b>William H. Johnson MD</b>   |  |                     |   |   |  |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
| 29c. License number<br><b>1047556</b>   |  |                     |   |   |  |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
| 29d. Date signed (Month, Day, Year)<br><b>2/7/97</b>  |  |                     |   |   |  |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>WILLIAM H. JOHNSON, 187 THOMAS JOHNSON DRIVE, FREDERICK, MD 21702</b>  |  |                     |   |   |  |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 10 1997</b>   |  |                     |   |   |  |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |
| 32. Registrar's Signature<br><b>John A. ...</b>   |  |                     |   |   |  |  |   |  |   |    |                       |   |    |                     |    |                 |    |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and to the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06397

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George Wesley Hawkins, Sr.

2. Date of Death

February 5, 1997

3. Time of Death

5:30 PM

4a. Facility Name (If not institution, give street and number)

Manor Care Potomac

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

217-14-7783

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

if Under 1 Year

Months Days

if Under 24 Hrs.

Hours Min.

8. Date of Birth

June 30, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Damascus

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10117 Lewis Drive

10f. Zip Code

20872

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: W.W. II

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

James Bradley Hawkins

18. Mother's Name (First, Middle, Maiden Surname)

Hattie M. King

19a. Informant's Name/Relationship (Type, Print)

Alice May Fritz- Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6106 Quinn Orchard Road, Frederick, Md. 21704

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Wesley Grove

Date

2/8/97

20c. Location - City or Town, State

Woodfield, Md.

21. Signature of Funeral Service Licensee

Olin L. Molesworth

22. Name and Address of Facility

Olin L. Molesworth, P.A., Funeral Home  
26401 Ridge Rd., Damascus, Md. 20872

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

cause of the prostate metastatic

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

recent spinal cord infarction

recent aortic aneurysm repair

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

David A. Blass MD

29c. License number

D23911

29d. Date signed (Month, Day, Year)

Feb. 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David A. Blass MD

9410 Old Georgetown Road, Bethesda, Md. 20814

31. Date filed (Month, Day, Year)

FEB 07 1997

32. Registrar's Signature

David A. Blass MD

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

5

739 - - -

7



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06398

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joyce K. Hendrickson

2. Date of Death

February 13, 1997

3. Time of Death

9:15 AM

4a. Facility Name (If not institution, give street and number)

5503 Huntington Parkway

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

363-22-2447

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 1, 1925

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5503 Huntington Parkway

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Navar Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)Engineering Analyst/  
Tax Expert

16b. Kind of Business/Industry

U.S. Government/  
Tax Preparation

17. Father's Name (First, Middle, Last)

Bruno Krabbe

18. Mother's Name (First, Middle, Maiden Surname)

Sue Thompson

19a. Informant's Name/Relationship (Type, Print)

Robert G. Hendrickson/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5503 Huntington Pkwy., Bethesda, Maryland 20814

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

Feb. 14, 1997

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee



M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/  
7557 Wisconsin Avenue  
Bethesda, Maryland 20814-3501Bethesda-Chevy  
Chase, Inc.23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Metastatic Ovarian Cancer

Approximate  
Interval Between  
Onset and Death

14 Months

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D22086

29d. Date signed (Month, Day, Year)

February 13, 1997

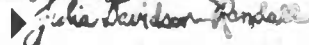
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick P. Smith, M.D. 5401 Western Avenue, NW, Washington, D.C. 20015

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06399

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |
|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES PAUL HILL</b>  |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>5</b> , Year <b>1997</b>   |  | 3. Time of Death<br><b>16:05</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>WASHINGTON COUNTY HOSPITAL</b>   |  | 4b. City, Town, or Location of Death<br><b>HAGERSTOWN</b>   |  | 4c. County of Death<br><b>WASHINGTON</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-24-9825</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.  | If Under 1 Year<br>Months Days                       | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>MAY 10, 1929</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>VIRGINIA</b>   |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  |   |  |  |
|   | 10a. State<br><b>MARYLAND</b>   | 10b. County<br><b>FREDERICK</b>  | 10c. City, Town or Location<br><b>THURMONT</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>11932 LUCEY RD.</b>  |  | 10f. Zip Code<br><b>21788</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                      |  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>EQUIPMENT OPERATOR</b>  |  | 16b. Kind of Business/Industry<br><b>HIGHWAY DEPARTMENT</b>   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>ERNEST EUGENE HILL</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FAY MARIE CAMERON</b>   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>PHYLLIS B. HILL (WIFE)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11932 LUCEY RD., THURMONT, MD 21788</b>       |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>RESTHAVEN MEMORIAL GRDNS</b>   |  | 20c. Location - City or Town, State<br><b>2/8/97 FREDERICK, MARYLAND</b>   |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A.<br/>615 E. MAIN ST., THURMONT, MD 21788</b>                 |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |  |   |  |  |
| Physician<br>/Medical<br>Examiner   | Immediate Cause (Final disease or condition resulting in death)<br><b>a. Myocardial infarction</b><br>Due to (or as a consequence of):  |  |   |  | Approximate Interval Between Onset and Death<br><b>&lt; 24h</b>  |
|   | b. Due to (or as a consequence of):   |  |   |  |  |
|   | c. Due to (or as a consequence of):   |  |   |  |  |
|   | d. Due to (or as a consequence of):   |  |   |  |  |
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>diabetes, hypertension</b>  |   |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)                                       |   | 28b. Time of Injury<br><b>M</b>                      |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |  |
| 29. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |  |  |
| 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>D31058</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>2-7-97</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GENE F. ASHE, M.D. WOODSBORO MEDICAL CENTER, WOODSBORO, MD 21798</b>   |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 10 1997</b>   |   | 32. Registrar's Signature<br>  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 06400

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Angeline D. High

2. Date of Death

February 15, 1997

3. Time of Death

5:55 PM

4a. Facility Name (If not institution, give street and number)

4610 Wissahican Avenue

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

190-24-1910

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 6, 1931

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4610 Wissahican Avenue

10f. Zip Code

20853

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Contract Specialist

16b. Kind of Business/Industry

Public Health Service

17. Father's Name (First, Middle, Last)

Antonio Maisano

18. Mother's Name (First, Middle, Maiden Surname)

Antonia Madaferi

19a. Informant's Name/Relationship (Type, Print)

Donald E. High

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4610 Wissahican Avenue Rockville, Maryland 20853

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

2/18/97

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Andrew J. Cole

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.  
500 University Blvd., W. Silver Spring, MD 20901

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Creutzfeldt-Jakob Disease

Approximate Interval Between Onset and Death

4 Months

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Eric M. Pearlman MD PhD

29c. License number

N1808

29d. Date signed (Month, Day, Year)

February 16, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eric M. Pearlman MD PhD, Johns Hopkins Hospital

31. Date filed (Month, Day, Year)

FEB 19 1997

32. Registrar's Signature

J. Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

25



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06401

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Milton Davis Huettel

2. Date of Death

February 13, 1997

3. Time of Death

9:15pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

459-68-6177

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

54

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

9-30-1942

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

#3 Royal Forrest Court

10f. Zip Code

20904

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Research Entomologist

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

Milton E. Huettel

18. Mother's Name (First, Middle, Maiden Surname)

Hellen Davis

19a. Informant's Name/Relationship (Type, Print)

Robin Huettel

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

#3 Royal Forrest Court Silver Spring, MD 20904

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Crematory

Date

2-15-1997 Brentwood, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi Funeral Home

11800 New Hampshire Ave. Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Brain tumor

Approximate interval between Onset and Death

Many years

a. Due to (or as a consequence of):

Aspiration pneumonia

b. Due to (or as a consequence of):

sepsis

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Chahar Alsharif

29c. License number

D43496

29d. Date signed (Month, Day, Year)

Feb. 14, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohammed A. Khalid 8830 Cameron Court Silver Spring.

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Julia Davidson-Rodale

State  
Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,





97 06402

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|---|--|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Henry B. Hartzler  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>February 18, 1997  |  |   |  | 3. TIME OF DEATH<br>12:42 p.m.  |  |  |  |  |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>161-10-6975   |  |  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>88 YRS. |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>August 27, 1908  |  | 8. BIRTHPLACE (State or Foreign Country)<br>York Pennsylvania |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Laurelwood Nursing Home  |  |  |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Elkton   |  |  |  | 9c. COUNTY OF DEATH<br>Cecil   |  |   |  |  |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |  |  |
| 10a. STATE<br>Delaware   |  |  |  | 10b. COUNTY<br>New Castle  |  |   |  | 10c. CITY, TOWN OR LOCATION<br>Newark   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>206 East Cobblefield Court   |  |  |  |  |  |   |  | 10f. ZIP CODE<br>19713  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Management  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Bell Telephone Company Of Pennsylvania  |  |  |  |  |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Rollin Hartzler   |  |  |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Bragdon   |  |  |  |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Lynne B. Powers  |  |  |  |  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>206 E. Cobblefield Ct. Newark, Delaware 19713  |  |  |  |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>R.A. Ferris & Co. 2/20/97   |  |   |  | 20c. LOCATION — City or Town, State<br>West Chester Pennsylvania  |  |  |  |  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  |  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Robert T. Jones & Foard, Inc.<br>122 West Main Street Newark, Delaware 19711  |  |  |  |  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. CORONARY ARTERY DISEASE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. CORONARY ARTERY DISEASE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. HYPERTENSIVE CARDIOVASCULAR DISEASE.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  | Approximate interval Between Onset and Death |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  |   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  |  |  |   |  | 29c. LICENSE NUMBER<br>D 07463  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br>2/18/97   |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>ROLANDO NAJERA, M.D. CLAYTON BUILDING, NORTH ST. ELKTON, MD. 21921  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 19 1997   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |  |  |  |  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06403

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CARL E. HORNBERGER

2. Date of Death

Month  
02Day  
21Year  
97

3. Time of Death

0707 a m

4a. Facility Name (If not institution, give street and number)

KENT &amp; QUEEN ANNES HOSPITAL

4b. City, Town, or Location of Death

CHESTERTOWN

4c. County of Death

KENT

Funeral  
Director

5. Social Security Number

212-36-1063

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan 25 1938

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Queen Anne

10c. City, Town or Location

Crumpton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

325 Broad St.

10f. Zip Code

21628

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

carpenter

16b. Kind of Business/Industry

construction

17. Father's Name (First, Middle, Last)

Norman Hornberger

18. Mother's Name (First, Middle, Maiden Surname)

Ida Meekins

19a. Informant's Name/Relationship (Type, Print)

Norma Wolfson (sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Box 247 Crumpton, MD 21628

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Maryland State Veterans

Date

Feb. 25  
1997

20c. Location - City or Town, State

Crownsville, Maryland

21. Signature of Funeral Service Licensee

[Signature] M00510

22. Name and Address of Facility  
Galena Funeral Home of Stephen L. Schaech  
Box 235 Galena, MD 2163523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NEUROFIBROMATOSIS

MULTINFARCT DEMENTIA

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

[Signature] H A Noble MD

29c. License number

D41587

29d. Date signed (Month, Day, Year)

2/21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Helen A. Noble MD 122 Spear Rd. Chestertown, MD 21620

31. Date filed (Month, Day, Year)

FEB 24 1997

32. Registrar's Signature

[Signature] Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

8+1/1A



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06404

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George David Harris

2. Date of Death

Month

Day

Year

Feb. 22, 1997 0610

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Carroll County General Hospital

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

5. Social Security Number

236-68-4918

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)

April 10 1943

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1107 Viking Court

10f. Zip Code

21158

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

salesman

16b. Kind of Business/Industry

auto

17. Father's Name (First, Middle, Last)

George M. Harris

18. Mother's Name (First, Middle, Maiden Surname)

Mary Epperly

19a. Informant's Name/Relationship (Type, Print)

Carolyn Harris, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1107 Viking Court, Westminster, MD 21158

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Manchester Baptist Church Cem.

Date  
02/24/97

20c. Location - City or Town, State

Manchester, MD

21. Signature of Funeral Service Licensee

Katherine Lutes - Switzer

22. Name and Address of Facility

Pitts Funeral Home

412 Washington Rd., Westminster, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. NON-SMALL CELL LUNG CANCER

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

7 mos.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Flavio Kruter MD

29c. License number

D35398

29d. Date signed (Month, Day, Year)

2/22/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FLAVIO KRUTER, MD - 684A Poole Rd. - Westminster, MD 21157

31. Date filed (Month, Day, Year)

FEB 24 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



97 06405

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WILLIAM A. HILDEBRAND</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>20</b> YEAR <b>97</b>  |  | 3. TIME OF DEATH<br><b>02:55 AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-14-4011</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>July 19, 1916</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Carroll County General Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Westminster</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Carroll</b>  |  |  |  | 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Carroll</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Finksburg</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>2012 Sandymount Road</b>  |  |
| 10f. ZIP CODE<br><b>21048</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII</b>  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>worker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Good Humor Ice Cream</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William A. Hildebrand Sr</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Edith Alts</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Margaret Hildebrand, wife</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2012 Sandymount Rd., Finksburg, MD 21048</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Garrison Forest Cemetery</b><br><b>02/24/97</b>  |  | 20c. LOCATION — City or Town, State<br><b>Owings Mills, MD</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Katherine Pritts - Switzer</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Pritts Funeral Home &amp; Chapel</b><br><b>412 Washington Rd., Westminster, MD</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>LUNG CANCER</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>LUNG CANCER</b><br>Approximate Interval Between Onset and Death: <b>few months</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b.<br>c.<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Emphysema</b><br><b>AORTIC ANEURYSM.</b> |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>N. Carrara MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D29246</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2 20 97</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>A. RAPPARA, 212 WASHINGTON APTS. WESTMINSTER MD 21157</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 21 1997</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Richard Randall</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician, TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06406

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edna May Howard

2. Date of Death

Month Day Year  
Feb. 19 1997

3. Time of Death

1:00 AM

4a. Facility Name (If not institution, give street and number)

2036 Red River Road

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

216-05-0550

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 8, 1906

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2036 Red River Road

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (14 or 5+)

none

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Retail Sales

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

Silas Gardner

18. Mother's Name (First, Middle, Maiden Surname)

Minerva Trone

19a. Informant's Name/Relationship (Type, Print)

Shirley M. Gardner (niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2036 Red River Road Sykesville, Md. 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woddlawn Cemetery

Date

2/21/97 Baltimore, Md.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Jeffrey N. Zumbrun

22. Name and Address of Facility

Jeffrey N. Zumbrun Funeral Home  
6028 Sykesville Road Sykesville, Md. 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, heart failure, etc. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Aortic Insufficiency

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert J. Moss, MD

29c. License number

032882

29d. Date signed (Month, Day, Year)

02/19/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert J. Moss 114 Business Center Dr. Reisterstown, Md 21136

31. Date filed (Month, Day, Year)

FEB 20 1997

32. Registrar's Signature

John A. Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06407

## Certificate of Death

Reg. No.

|   |  |  |   |                                |  |  |   |  |
|---|--|--|---|--------------------------------|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>BETHANY MARIE HARPSTER</b>  |  |   |                                | 2. Date of Death<br>Month <b>FEB.</b> Day <b>15</b> , Year <b>1997</b>   |  | 3. Time of Death<br><b>1130 AM</b>  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>404 EAST MAIN STREET</b>  |  |   |                                | 4b. City, Town, or Location of Death<br><b>WESTMINSTER</b>   |  | 4c. County of Death<br><b>CARROLL</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>216-31-7792</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>6</b> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>JAN. 12, 1991</b>                                      | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                     |  |
|   | Usual Residence of Decedent  |  |   |                                |  |  |   |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD.</b>   | 10b. County<br><b>CARROLL</b>  | 10c. City, Town or Location<br><b>WESTMINSTER</b>   |                                |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br><b>404 EAST MAIN ST.</b>   |  |   | 10f. Zip Code<br><b>21157</b>  |  | 10g. Citizen of What Country?<br><b>USA.</b>   |   |  |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                         |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>KINDERGARTEN</b><br>College (1-4 or 5+) <b>STUDENT</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   |                                | 16b. Kind of Business/Industry   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>LARRY PAUL HARPSTER</b>  |  |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>DIANNE LYNN MULLER</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>DIANNE L. HARPSTER -MOTHER</b>  |  |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>404 E. MAIN ST., WESTMINSTER, MD. 21157</b>  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MEADOW BRANCH CEM. 2/18/97</b>   |                                | 20c. Location - City or Town, State<br><b>WESTMINSTER, MD.</b>   |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>FLETCHER FUNERAL HOME<br/>254 E. MAIN ST., WESTMINSTER, MD. 21157</b>  |                                |  |  |   |  |
|   | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediata Cause (Final disease or condition resulting in death)<br><br>a. <u>Pending</u> <b>Oxycodone Intoxication</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |                                |  |  |   | Approximate Interval Between Onset and Death   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                                |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                |  |  |   |  |
|   | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input checked="" type="checkbox"/> Pending Investigation<br>6 <input checked="" type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>2/15/97</b>  |                                | 28b. Time of Injury<br><b>9:30 a M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|   | 28d. Describe how injury occurred<br><b>Unknown</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>404 East Main Street Westminister, Carroll Co.</b>   |                                |  |  |   |  |
|   | 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |                                |  |  |   |  |
|   | 29b. Signature and title of certifier<br>  |  |   |                                | 29c. License number<br><b>O.C.M.E</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>FEB. 16, 1997</b>                                     |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |                                |  |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br><b>FEB 19 1997</b>  |  | 32. Registrar's Signature<br>   |                                |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06408

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sandra K. Holter

2. Date of Death  
Month Day Year

February 20, 1997 2:36pm

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

GENESIS NURSING HOME

4b. City, Town, or Location of Death

LA PLATA

4c. County of Death

CHARLES

5. Social Security Number

212-38-5495

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

MARCH 14, 1940

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

WALDORF

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13311 POPLAR HILL ROAD

10f. Zip Code

20601

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify:

WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

18a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOUSE WIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

LUTHER WOTRING

18. Mother's Name (First, Middle, Maiden Summa)

ELEANOR TETS

19a. Informant's Name/Relationship (Type, Print)

DAVID C. HOLTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13311 POPLAR HILL ROAD WALDORF, MARYLAND 20601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

TRINITY MEMORIAL GARDENS

Data

FEB. 24  
1997

20c. Location - City or Town, State

WALDORF, MARYLAND

21. Signature of Funeral Service Licensee

BENJAMIN M. MATTHEWS M-00658

22. Name and Address of Facility

THE HUNTT FUNERAL HOME, INC.  
P.O. BOX 156 WALDORF, MARYLAND 2060423a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)Advanced Aggressive Dementia. x3 yrs.  
Due to (or as a consequence of): Alzheimer's / Pick's typeSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
2 ☐ Accidental 6 ☐ Could not be  
3 ☐ Suicide 6 ☐ determined  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D20629

29d. Date signed (Month, Day, Year)

FEB. 21/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEORGE H. WATKINS: WALDORF, MD. 20603

31. Date filed (Month, Day, Year)

FEB 24 1997

32. Registrar's Signature

Julia Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06409

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CLIFFORD

OWENS

HOLLAWAY

2. Date of Death

Month

Day

Year

FEBRUARY 20, 1997

3. Time of Death

1:00 PM

4a. Facility Name (If not institution, give street and number)

SOUTHERN MARYLAND HOSPITAL CENTER

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGE'S

Funeral  
Director

5. Social Security Number

458-26-0986

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

JAN. 23, 1925

9. Birthplace (State or Foreign Country)

TEXAS

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

BRANDYWINE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17350 RIVER AIRPORT ROAD

10f. Zip Code

20613

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1942-  
194513. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
5College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

SUPERINTENDANT OF CORRECTIONS

16b. Kind of Business/Industry

PRINCE GEORGE'S COUNTY  
BOARD OF CORRECTIONS

17. Father's Name (First, Middle, Last)

SMITH

OWENS

HOLLAWAY

18. Mother's Name (First, Middle, Maiden Surname)

LOIS HARP

19a. Informant's Name/Relationship (Type, Print)

ETHEL HOLLAWAY - WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17350 RIVER AIRPORT ROAD, BRANDYWINE, MD. 20613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

RESURRECTION CEMETERY, FEB. 22, 1997, CLINTON, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

MGB  
MARK G. BROHAWN

MO0053

22. Name and Address of Facility

THE HUNTT FUNERAL HOME, INC.  
P.O. BOX 156, WALDORF, MARYLAND 2060423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Atherosclerotic Heart Disease

Due to (or as a consequence of):

b. Coronary Vascular Accident

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Yes

2 mo

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Thomas L. Fieldson MD DO1923

29c. License number

29d. Date signed (Month, Day, Year)

FEBRUARY 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS L. FIELDSON, M.D., 2068 CRAIN HIGHWAY, WALDORF, MARYLAND 20601

31. Date filed (Month, Day, Year)

FEB 24 1997

32. Registrar's Signature

Julia Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

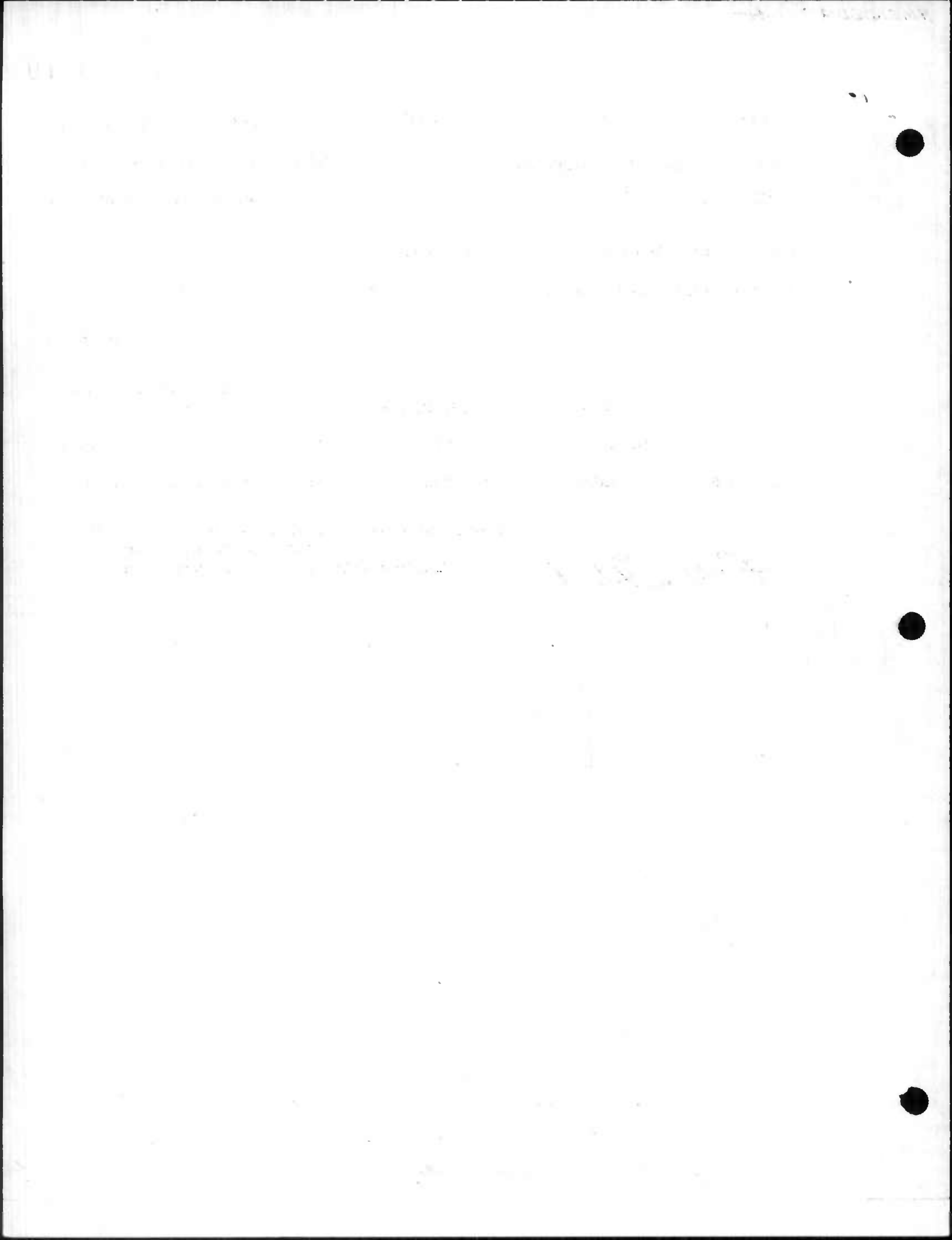
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





DMMH 16 Rev 6/95



97 06411

DHHM 16 Rev 6/95



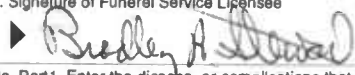
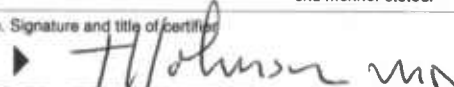
Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06412

Reg. No.

|  |  |  |   |  |   |  |   |  |
|--|--|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Lettie Olive JOHNSTON</b>   |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>9</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>9:45 PM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Garrett County Memorial Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Oakland</b>  |  | 4c. County of Death<br><b>Garrett</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>235-36-2402</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>94</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Mar. 26, 1902</b>                                 |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>   |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Garrett</b>   |  | 10c. City, Town or Location<br><b>Oakland</b>   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>1113 Mary Drive</b>  |  | 10f. Zip Code<br><b>21550</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) _____  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cook</b>                          |  | 16b. Kind of Business/Industry<br><b>Hospital</b>   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Adam A. Hevener</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Diana ----- Dodrill</b>   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ralph J. Hight, Son</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>911 Broadford Road, Oakland, MD 21550</b>   |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. State Mem. Gardens</b>   |  | 20c. Date<br><b>2/13/97</b>   |  | 20d. Location - City or Town, State<br><b>Elkins, WV</b>                                    |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Stewart Funeral Home<br/>32 S. Second St., Oakland, MD 21550</b>   |  |   |  |
|  | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Pneumonia</b><br>Due to (or as a consequence of):<br>b. _____<br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____<br>Approximate Interval Between Onset and Death<br><b>3 days</b> |  |   |  |   |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |   |  |   |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |   |  |   |  |   |  |
| Physician<br>/Medical<br>Examiner  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Ischemic Cerebrovascular Disease</b><br><b>Arteriosclerotic Heart Disease</b>   |  |   |  |   |  |   |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |  |   |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |   |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 28d. Describe how injury occurred  |  |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |  |   |  |
|  | 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D15333</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/19</b>  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Thomas Johnson, MD 311 N. Fourth St., Oakland, Maryland 21550</b>   |  |   |  |   |  |   |  |
|  | 31. Date filed (Month, Day, Year)<br><b>FEB 18 1997</b>  |  |   |  | 32. Registrar's Signature<br>  |  |   |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



97 06413

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Freda Mae Jack</u>  |  |  |  | 2. DATE OF DEATH<br>MONTH <u>02</u> DAY <u>10</u> YEAR <u>97</u>  |  | 3. TIME OF DEATH<br><u>4:45 A M</u>   |  |
| 4. SOCIAL SECURITY NUMBER<br><u>218-24-1125</u>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><u>82</u> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><u>Aug. 31, 1914</u>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><u>West Virginia</u>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><u>Pleasant View Nursing Home</u>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Mt. Airy</u>  |  |
| 9c. COUNTY OF DEATH<br><u>Carroll</u>  |  |  |  | 10a. STATE<br><u>Maryland</u>   |  |   |  |
| 10b. COUNTY<br><u>Carroll</u>  |  |  |  | 10c. CITY, TOWN OR LOCATION<br><u>Mt. Airy</u>  |  |   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><u>4101 Baltimore National Pike</u>   |  |   |  |
| 10f. ZIP CODE<br><u>21771</u>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>United States</u>   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMY FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>White</u>                               |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>8</u><br>College (1-4 or 5+) <u>College</u>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><u>Homemaker</u>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Own home</u>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>John Faulkner</u>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Lena</u>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Jack J. Jack - Son</u>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>13111 Catocin Furnace Rd., Thurmont, Md. 21788</u>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Forest Oak Cemetery 2/13/97</u>  |  | 20c. LOCATION — City or Town, State<br><u>Gaithersburg, Md.</u>   |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Olin L. Molesworth</u>                                |  |
| 22. NAME AND ADDRESS OF FACILITY<br><u>Olin L. Molesworth, P.A., Funeral Home</u><br><u>26401 Ridge Rd., Damascus, Md. 20872</u>   |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>DEMENTIA</u><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Hypertension, osteoarthritis,</u><br><u>Atherosclerotic heart disease</u><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide  |  |   |  |   |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><u>M</u>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Melvin Jacob Ford</u> MD   |  |  |  | 29c. LICENSE NUMBER<br><u>201016/006588</u>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>2/10/97</u>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>Melvin J Ford MD 4801 Dorsey Hall Drive</u><br><u>Ellicott City MD 21042</u>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><u>FEB 12 1997</u>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><u>John A. Dwyer</u>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general introduction to the subject of the study.

2. The second part of the report is a detailed description of the methods used in the study.

3. The third part of the report is a discussion of the results of the study.

4. The fourth part of the report is a conclusion and a list of references.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06414

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edris Ione Jones

2. Date of Death

Month Day Year  
February 14, 1997

3. Time of Death

3:15 P.M.

4a. Facility Name (If not institution, give street and number)

7811 Stratford Road

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

572-34-8375

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
August 6, 1903

9. Birthplace (State or Foreign Country)

Utah

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7811 Stratford Road

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Musician

16b. Kind of Business/Industry

Entertainment Industry

17. Father's Name (First, Middle, Last)

John Angus Christensen

18. Mother's Name (First, Middle, Maiden Surname)

Mary McKay

19a. Informant's Name/Relationship (Type, Print)

Ronald G. Capalaces/Caregiver

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6512 Jay Miller Drive, Falls Church, Virginia 22041

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Ogden City Cemetery

Date

February 22, 1997

20c. Location - City or Town, State

Ogden, Utah

21. Signature of Funeral Service Licensee

M00846

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.  
7557 Wisconsin Avenue, Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Cerebrovascular Accident

1 Week

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Susan Baruch M.D.

29c. License number

D39563

29d. Date signed (Month, Day, Year)

February 17, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Susan G. Baruch, M.D., 10215 Fernwood Road, Suite 100, Bethesda, Maryland 20817

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

J. Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06415

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Mary Marguerite Jones  |  | 2. Date of Death<br>Month Day Year<br>February 18, 1997   |  | 3. Time of Death<br>3:26 PM  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Montgomery General Hospital  |  | 4b. City, Town, or Location of Death<br>Olney   |  | 4c. County of Death<br>Montgomery  |
| Funeral<br>Director   | 5. Social Security Number<br>578-03-7256   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>78 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>May 30, 1918      | 9. Birthplace (State or Foreign Country)<br>Maryland   |
|   | Usual Residence of Decedent  |  |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland   | 10b. County<br>Prince Georges  | 10c. City, Town or Location<br>Hyattsville  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|   | 10e. Street and Number<br>7611 23rd Avenue   |  | 10f. Zip Code<br>20783  |  | 10g. Citizen of What Country?<br>USA   |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:             |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 Collage (1-4 or 5+)   |  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Ticket Agent  |  | 16b. Kind of Business/Industry<br>Railroad  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Charles Edward Jones, Sr.   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Wilhelmina Griebel   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Wilhelmina Carr / Sister   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4804 Stockton Lane, Hyattsville, Maryland 20784                  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Fort Lincoln Cemetery   |  | 20c. Location - City or Town, State<br>Brentwood, Maryland   |
|   | 21. Signature of Funeral Service Licensee  |  | 22. Name and Address of Facility Hines-Rinaldi Funeral Home<br>11800 New Hampshire Avenue<br>Silver Spring, Maryland 20904  |  |  |
|   | 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |
| Physician<br>/Medical<br>Examiner   | Immediate Cause (Final disease or condition resulting in death)<br>a. multi organ failure<br>Due to (or as a consequence of):<br>b. small bowel obstruction<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.  |  | Approximate Interval Between Onset and Death<br>DAYS.<br>DAYS.  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>myasthenia gravis  |  |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No            |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |   |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>M 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
|   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |
| 29b. Signature and title of certifier   |  | 29c. License number<br>D38457  |   | 29d. Date signed (Month, Day, Year)<br>FEBRUARY 18, 1997 |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>N GORDON 1811 Prince Philip Dr Olney MD 20832 |  |  |   |  |  |
| State<br>Registrar  | 31. Date filed (Month, Day, Year)<br>FEB 21 1997   |  | 32. Registrar's Signature<br>Julia Davidson-Randall   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

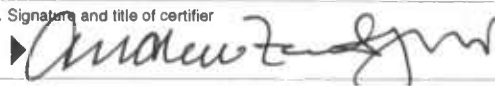
State of Maryland / Department of Health and Mental Hygiene

97 06416

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Sylvester Leroy Jackson</b>   |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>14</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>7:29 a.m.</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Frederick</b>  |  | 4c. County of Death<br><b>Frederick</b>  |  |
| 5. Social Security Number<br><b>217-36-8257</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>59</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 6, 1937</b>                                     |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |   |  |   |  |  |  |
| Usual Residence of Decedent  |  |   |  |   |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Frederick</b>   |  | 10c. City, Town or Location<br><b>Jefferson</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>4116 Springview Drive</b>   |  |   |  | 10f. Zip Code<br><b>21755</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>7th</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>   |  | 16b. Kind of Business/Industry<br><b>Construction</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>George Jackson</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillie Askins</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Maxine Pearson (Friend)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4116 Springview Dr., Jefferson, MD 21755</b>  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rest Haven Mem. Gdns</b>   |  | 20c. Date<br><b>2/21/97</b>   |  | 20d. Location - City or Town, State<br><b>Frederick, MD</b>                                    |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>SNOWDEN FUNERAL HOME, P.A.<br/>ROCKVILLE, MD 20850</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>ASCVD</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><b>Years</b> |  |   |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |  |
| 28d. Describe how Injury occurred  |  |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
| 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D35164</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>February 17, 1997</b>                                |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Andrew Zarick, Jr. MD 1080 W. Patrick St Frederick, MD 21703</b>  |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 20 1997</b>  |  |   |  | 32. Registrar's Signature<br>  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be dated for use as the burial-transit once.

Physician  
/Medical  
Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06417

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |
|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Dorothy Jackson   |  | 2. Date of Death<br>Month Day Year<br>February 22 1997  |  | 3. Time of Death<br>0850   |
|   | 4a. Facility Name (If not institution, give street and number)<br>Union Hospital  |  | 4b. City, Town, or Location of Death<br>Elkton  |  | 4c. County of Death<br>Cecil   |
| Funeral<br>Director   | 5. Social Security Number<br>212-28-8003  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F         | 7. Age (In yrs. last birthday)<br>93 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br>10 6 03  |  | 9. Birthplace (State or Foreign Country)<br>Trenton, NJ   |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  | 10a. State<br>MD  |  | 10b. County<br>Cecil   |
|   | 10c. City, Town or Location<br>904 Frenchtown Road  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
|   | 10e. Street and Number<br>904 Frenchtown Road   |  | 10f. Zip Code<br>21921  |  | 10g. Citizen of What Country?<br>USA   |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (14 or 5+)<br>No Record  |  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Owner/Operator   |  | 16b. Kind of Business/Industry<br>Paint Sales   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>No Record  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>No Record  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Violet Richards - Friend  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>943 Frenchtown Road, Elkton, MD 21921  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gilpin Manor Memorial Cemetery  |  | 20c. Location - City or Town, State<br>Elkton, Maryland  |
|   | 21. Signature of Funeral Service Licensee<br>Frank C. Mayer Jr.   |  | 22. Name and Address of Facility<br>Spicer-Mullikin Funeral Homes, Inc.<br>1000 N. DuPont Pkwy, New Castle, DE 19720  |  |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                       |  |   |  | Approximate Interval Between Onset and Death   |
|   | Immediate Cause (Final disease or condition resulting in death)<br>e. <i>Branchopneumonia</i>   |  |   |  | 2 days   |
|   | Due to (or as a consequence of):<br>b. <i>Respiratory failure</i>   |  |   |  | 2 days   |
|   | Due to (or as a consequence of):<br>c. <i>Sepsis -</i>  |  |   |  | 2 days   |
|   | Due to (or as a consequence of):<br>d.  |  |   |  |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Generalized debilitated condition</i><br><i>Underweight</i><br><i>Peripheral vascular disease</i>                  |  |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)  | 28b. Time of Injury<br>M  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |  |
| 29b. Signature and title of certifier<br><i>Jayantilal K Patel</i>  |   | 29c. License number<br>A22307  |   | 29d. Date signed (Month, Day, Year)<br>2/22/97                                       |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>JAYANTILAL K PATEL MD 123 SINGERLYAIE, ELKTON MD 21921  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 25 1997  |   | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>                             |   |  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06418

Items: 23 Part I, II, 27 per MEO G-745 3/11/97 <sup>reb</sup> Certificate of Death

Reg. No.

|  |  |  |   |   |  |  |  |
|--|--|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>FRANK EARL JACKSON, Jr.</b>   |  |   |   | 2. Date of Death<br>Month <b>February</b> Day <b>19</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>0905a</b>   |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>108 EDGEWOOD #4</b>   |  |   |   | 4b. City, Town, or Location of Death<br><b>EDGEWOOD</b>  |  | 4c. County of Death<br><b>HARFORD</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-28-1625</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                       | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.  | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>May 9, 1931</b>                                      | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                      |
|  | Usual Residence of Decedent  |  |   |   |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Harford</b>  | 10c. City, Town or Location<br><b>Edgewood</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>108 Edgewood Road, P.O. Box 1061</b>  |  |   | 10f. Zip Code<br><b>21040</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>          |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Seven Years</b><br>College (1-4 or 5+) -----   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Grounds Maintenance</b>           |   | 16b. Kind of Business/Industry<br><b>Edgewood Arsenal</b><br><b>Edgewood, Maryland</b>   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Frank Earl Jackson, Sr.</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Blanche O. Devonshire</b>   |  |  |  |
| Physician<br>/Medical<br>Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ross J. Patterson, Sr.</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 188, Perryville, Maryland 21903-0188</b> |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Asbury Cemetery</b>  |   | Date<br><b>2/24/97</b>   | 20c. Location - City or Town, State<br><b>Port Deposit, Maryland</b>                           |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   | 22. Name and Address of Facility<br><b>Lee A. Patterson &amp; Son Funeral Home</b><br><b>Perryville, Maryland 21903-0188</b>                          |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death)</b><br><b>a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR</b><br>Due to (or as a consequence of):<br><br><b>SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO IMMEDIATE CAUSE. ENTER UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) Last</b><br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |   |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |   |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CARCINOMA OF COLON</b>  |  |   |   |  |  |  |
|  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   |  |  |  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |   |  |  |  |
|  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   |  |  |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |   |  |  |  |
| State<br>Registrar   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |   |  |  |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |  |  |
|  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |   |  |  |  |
|  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>O.C.M.E.</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>February 20, 1997</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201</b> |  |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 1997</b>  |  | 32. Registrar's Signature<br> |   |   |  |  |  |

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06419

Item: 28d per MEO G-746 4/1/97 reb

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DANIEL EDWARD JAMES

2. Date of Death  
Month Day Year

FEBRUARY 18, 1997 9:40 P.M.

3. Time of Death

4a. Facility Name (If not institution, give street and number)

SHOCK TRAUMA CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-82-0278

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

33 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 20, 1964

9. Birthplace (State or Foreign Country)

Turkey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Woodbine

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6525 Day View Dr.

10f. Zip Code

21797

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 1986-

1990

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Disabled Veteran

16b. Kind of Business/Industry

Air Force

17. Father's Name (First, Middle, Last)

Arthur J. James, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Ila Nelle Hedrick

19a. Informant's Name/Relationship (Type, Print)

Arthur J. James, Jr. (father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6525 Day View Dr. Woodbine MD. 21797

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Carroll Cremation

Date

2/20/97

20c. Location - City or Town, State

Hampstead, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burrier-Queen Funeral Directors

1212 W. Old Liberty Rd. Winfield, MD 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Gunshot Wound of the back

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

{

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ OOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☒ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

2/18/97

28b. Time of Injury

8:34 AM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

subject shot BY POLICE

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

Home

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

6500 Day View Rd

Woodbine, Md

29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis J. Chute MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

FEBRUARY 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chute MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 21 1997

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06420

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM R. KELLY

2. Date of Death

FEB. 9 1997

3. Time of Death

6:50pm

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery County

5. Social Security Number

579-05-3744

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

November 16,

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

None

10b. County

None

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

250 Quackenbos Street, N.W.

10f. Zip Code

22012

10g. Citizen of What Country?

United States

of America

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☒ Yes ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

18a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Tax Investigator

16b. Kind of Business/Industry

Washington, D.C.

Government

17. Father's Name (First, Middle, Last)

Frank Kelly

18. Mother's Name (First, Middle, Maiden Surname)

Janie Kelly

19a. Informant's Name/Relationship (Type, Print)

Ronald Bernard Kelly /Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

250 Quackenbos Street, N.W., Washington, D.C.

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Ebenezer Baptist Cemetery

Date

February

20c. Location - City or Town, State

White Post, Virginia

21. Signature of Funeral Service Licensee #M00690

Howard A. Couson

22. Name and Address of Facility

Berry O. Waddy Funeral Home

Route 3, P.O. Box 165, Lancaster, Virginia 22503

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. SEPSIS, BILATERAL PNEUMONITIS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. MULTIPLE MYELOMA

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

(1) POLYCYTHEMIA (2) CORONARY ARTERY  
DISEASE (3) CHRONIC OBSTRUCTIVE PULMONARY  
DISEASE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24e. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier  
(Check only  
one)☒ Certifying Physician:☐ Medical Examiner:To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dr. A. Mannan MD

29c. License number

D24593

29d. Date signed (Month, Day, Year)

FEB. 9, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. MOHAMMED A. MANNAN, 3715 RHODE ISLAND AVE. MT. RAINIER, MD 20712

31. Date filed (Month, Day, Year)

FEB 20 1997

32. Registrar's Signature

Julia Davidson-Rodette

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

97 06421

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jane May KNOWLES

2. Date of Death

February 16, 1997

3. Time of Death

10:00pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

2729 Price Distillery Road

4b. City, Town, or Location of Death

Clarksburg

4c. County of Death

Frederick

5. Social Security Number

221-12-9918

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan 24, 1925

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Frederick10c. City, Town or Location  
Clarksburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2729 Price Distillery Road

10f. Zip Code

20871

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
116a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Administrative

16b. Kind of Business/Industry

National Geographic

17. Father's Name (First, Middle, Last)

Edward Charles

BUNN

18. Mother's Name (First, Middle, Maiden Surname)

Lucinda Ruth

HARTZ

19a. Informant's Name/Relationship (Type, Print)

Edward L. Knowles/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1616 Hollins Street, Baltimore, Maryland 21223

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Smithsburg Crematory Feb 18, 1997

Date

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee



MD0706

22. Name and Address of Facility

Keeney &amp; Basford P.A. Funeral Home

106 East Church Street, Frederick, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Acute Myocardial Infarction

Approximate  
Interval Between  
Onset and Death

&lt; 1 hr

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

D35404

29d. Date signed (Month, Day, Year)

February 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael A. Sauri, M.D., 9715 Medical Center Drive, Rockville, MD 20850

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06422

|   |  |  |                                 |  |  |  |  |  |
|---|--|--|---------------------------------|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>VERNON WILLARD KEFAUVER</b>   |  |                                 |  | 2. Date of Death<br>Month Day Year<br><b>February 10, 1997</b>   |  | 3. Time of Death<br><b>9:37 AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>   |  |                                 |  | 4b. City, Town, or Location of Death<br><b>Frederick</b>   |  | 4c. County of Death<br><b>Frederick</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>214010-2894</b>  |  | 6. Sex<br><b>1</b> M <b>2</b> F |  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 17, 1913</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Frederick</b>  |  | 10c. City, Town or Location<br><b>Frederick</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |                                 |  | 10e. Street and Number<br><b>713 Magnolia Avenue</b>   |  | 10f. Zip Code<br><b>21701</b>  |  |
|   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |                                 |  | 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:                       |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify:  |  |                                 |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Builder and Designer</b>   |  |                                 |  | 16b. Kind of Business/Industry<br><b>Materials Handling Systems</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Roy Jacob Kefauver</b>   |  |                                 |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Harriett Ruth Willard</b>  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joan Kefauver Hummer/daughter</b>   |  |                                 |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>713 Magnolia Ave., Frederick, Md. 21701</b>                                  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |  |                                 |  | 20b. Place of Disposition (Name of cemetery, crematory, or other place)<br><b>Smithsburg Crematory</b>   |  | 20c. Location - City or Town, State<br><b>Feb. 12, 1997 Smithsburg, Maryland</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Richard C.C. Basford M00021</b>  |  |                                 |  | 22. Name and Address of Facility<br><b>Keeney and Basford Funeral Home<br/>106 East Church Street, Frederick, Md. 21701</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Sepsis</b><br>Due to (or as a consequence of):<br>b. <b>Pneumonia</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                 |  | Approximate Interval Between Onset and Death<br><b>~5 days</b>   |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal Failure</b><br><b>Coronary Heart Disease</b><br><b>Cerebrovascular Accident</b>   |  |                                 |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> <input checked="" type="checkbox"/> No <b>3</b> Probably <b>4</b> Unknown                        |  |  |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> <input checked="" type="checkbox"/> No   |  |                                 |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> <input checked="" type="checkbox"/> No                                      |  |  |  |
|   | 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> <input checked="" type="checkbox"/> No   |  |                                 |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide   |  |                                 |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |  |
|   | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No   |  |                                 |  | 28d. Describe how injury occurred  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |                                 |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 29a. Certifier (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |                                 |  | 29b. Signature and title of certifier<br><b>Francis E. Becker MD</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29c. License number<br><b>030496 Md.</b>   |  |                                 |  | 29d. Date signed (Month, Day, Year)<br><b>2/10/97</b>  |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Francis E. Becker MD, 300 W. 9th St, Frederick Md 21701</b>   |  |                                 |  | 31. Date filed (Month, Day, Year)<br><b>FEB 11 1997</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>   |  |                                 |  | 33. Date of Death (Month, Day, Year)<br><b>FEB 10 1997</b>   |  |  |  |
|   | 34. Date of Death (Month, Day, Year)<br><b>FEB 10 1997</b>   |  |                                 |  | 35. Date of Death (Month, Day, Year)<br><b>FEB 10 1997</b>   |  |  |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06423

|   |   |   |   |  |  |  |   |  |  |   |  |
|---|---|---|---|--|--|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>James Nicholas Kasson   |   |   |  |  |  | 2. Date of Death<br>Month Day Year<br>February 19, 1997               |  | 3. Time of Death<br>8:15 A.M.  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>3810 Kelsey Street  |   |   |  |  |  | 4b. City, Town, or Location of Death<br>Silver Spring                 |  | 4c. County of Death<br>Montgomery  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br>214-60-7065  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>45 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>May 18, 1951                   |  | 9. Birthplace (State or Foreign Country)<br>Washington DC  |   |  |
|   | Usual Residence of Decedent   |   |   |  |  |  |   |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br>MD  |   | 10b. County<br>Montgomery   |  | 10c. City, Town or Location<br>Silver Spring   |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br>3810 Kelsey Street  |   |   |  | 10f. Zip Code<br>20906   |  | 10g. Citizen of What Country?<br>USA                                  |  |  |   |  |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1970-1971 |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White      |  |  |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>5+  |   |   |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Paralegal Technician  |  | 18b. Kind of Business/Industry<br>Federal Government                  |  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Thomas C. Kasson   |   |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Stella I. Lianos |  |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19e. Informant's Name/Relationship (Type, Print)<br>Thomas C. Kasson  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3810 Kelsey Street, Silver Spring, MD 20906   |  |   |  |  |   |  |
|   | 20e. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gate of Heaven Cemetery   |  | Date<br>2/21/97  |  | 20c. Location - City or Town, State<br>Silver Spring, MD              |  |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br>Francis J. Collins Funeral Home, Inc.<br>500 University Blvd., W. Silver Spring, MD 20901  |  |   |  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. Metastatic Lung Cancer<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |   |  |  |  |   |  |  |   |  |
|   | Approximate interval Between Onset and Death<br>3 Months  |   |   |  |  |  |   |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |  |
|   |   |   |   |  |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |  |  |   |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how Injury occurred  |  |   |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |   |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>   |   |  |  | 29c. License number<br>D-33224   |   | 29d. Date signed (Month, Day, Year)<br>February 19, 1997   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Ram S. Trehan, M.D. 50 W. Edmonston Drive #303, Rockville, MD 20852   |   |   |   |  |  |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>FEB 21 1997  |   | 32. Registrar's Signature<br>   |   |  |  |  |   |  |  |   |  |

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06424

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SERAFIN

Kolchev

2. Date of Death

February 17, 1997

3. Time of Death

11:00 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

196 Gold Kettle Drive

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

567-50-9738

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 20, 1905

9. Birthplace (State or Foreign Country)

Russia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

196 Gold Kettle Drive

10f. Zip Code

20878

10g. Citizen of What Country?

Russia

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Choir Director

16b. Kind of Business/Industry

Church

17. Father's Name (First, Middle, Last)

Nikolai Kolchev

18. Mother's Name (First, Middle, Maiden Surname)

Pelagea Rumiantzeva

19a. Informant's Name/Relationship (Type, Print)

Tanja Deev / Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

196 Gold Kettle Drive, Gaithersburg, Maryland 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Andrews Orthodox Cem. 2/22/97 Baltimore, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Dean J. Donnell

22. Name and Address of Facility

Hines-Rinaldi Funeral Home  
11800 New Hampshire Avenue  
Silver Spring, Maryland 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic adenocarcinoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Cheryl Winchell MD

29c. License number

DIASSS

29d. Date signed (Month, Day, Year)

February 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cheryl Winchell, M.D. 19241 Montgomery Village Ave, Gaithersburg

31. Date filed (Month, Day, Year)

FEB 21 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06425

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Vena Lovett Kaufman

2. Date of Death

February 15, 1997

3. Time of Death

6:53 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

11402 Cam Court

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

5. Social Security Number

497-28-5051

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 23, 1922

9. Birthplace (State or Foreign Country)

Kansas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11402 Cam Court

10f. Zip Code

20895

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
516a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

music teacher

16b. Kind of Business/Industry

self employed

17. Father's Name (First, Middle, Last)

Logan Lovett

18. Mother's Name (First, Middle, Maiden Surname)

Rebecca Williams

19a. Informant's Name/Relationship (Type, Print)

Victor Kaufman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11402 Cam Court, Kensington, Maryland 20895

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Chesapeake Crematory

Date

2-17-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rapp Funeral Services, P.A.  
933 Gist Avenue, Silver Spring, Maryland 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Non Hodgkins Lymphoma

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

10 months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D22235

29d. Date signed (Month, Day, Year)

February 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wesley Mason, M.D. 10810 Connecticut Avenue, Kensington, Maryland 20895

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06426

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |  |  |  |  |  |  |  |   |  |
|---|--|---|--|--|--|--|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Shen-Chih-Lian Koo</b>   |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>15</b> , Year <b>1997</b>   |  |  |  | 3. Time of Death<br><b>11:15 AM</b>  |  |  |  |   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>8930 Falls Farm Drive</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Potomac</b>   |  |  |  | 4c. County of Death<br><b>Montgomery</b>   |  |  |  |   |  |
| 5. Social Security Number<br><b>117-76-7254</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.   |  | If Under 1 Year<br>Months Days   |  | If Under 24 Hrs.<br>Hours Min.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 24, 1915</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>China</b>  |  |
| Usual Residence of Decedent   |  |   |  |  |  |  |  |  |  |  |  |   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Potomac</b>  |  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |   |  |
| 10e. Street and Number<br><b>8930 Falls Farm Drive</b>  |  |   |  | 10f. Zip Code<br><b>20854</b>  |  |  |  | 10g. Citizen of What Country?<br><b>China</b>  |  |  |  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Chinese</b>                          |  |  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Chin-Jung Shen</b>  |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Kui-Ying Chou</b>            |  |  |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Michael Koo / Son</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8930 Falls Farm Drive, Potomac, Maryland 20854</b>   |  |  |  |  |  |  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>   |  |  |  | Date<br><b>2/22/97</b>   |  | 20c. Location - City or Town, State<br><b>Silver Spring, Maryland</b>  |  |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Hines-Rinaldi Funeral Home<br/>11800 New Hampshire Avenue<br/>Silver Spring, Maryland 20904</b>   |  |  |  |  |  |  |  |   |  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Acute Myocardial Infarction</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |  |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>10 minutes</b>   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |   |  |
|   |  |   |  |  |  |  |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |  |   |  |
|   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |  |  |  |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D08546</b>   |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>February 15, 1997</b>                                    |  |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>John F. Tauber, M.D. 8218 Wisconsin Avenue, Bethesda, Maryland 20814</b>   |  |   |  |  |  |  |  |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 21 1997</b>   |  |   |  | 32. Registrar's Signature<br>   |  |  |  |  |  |  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

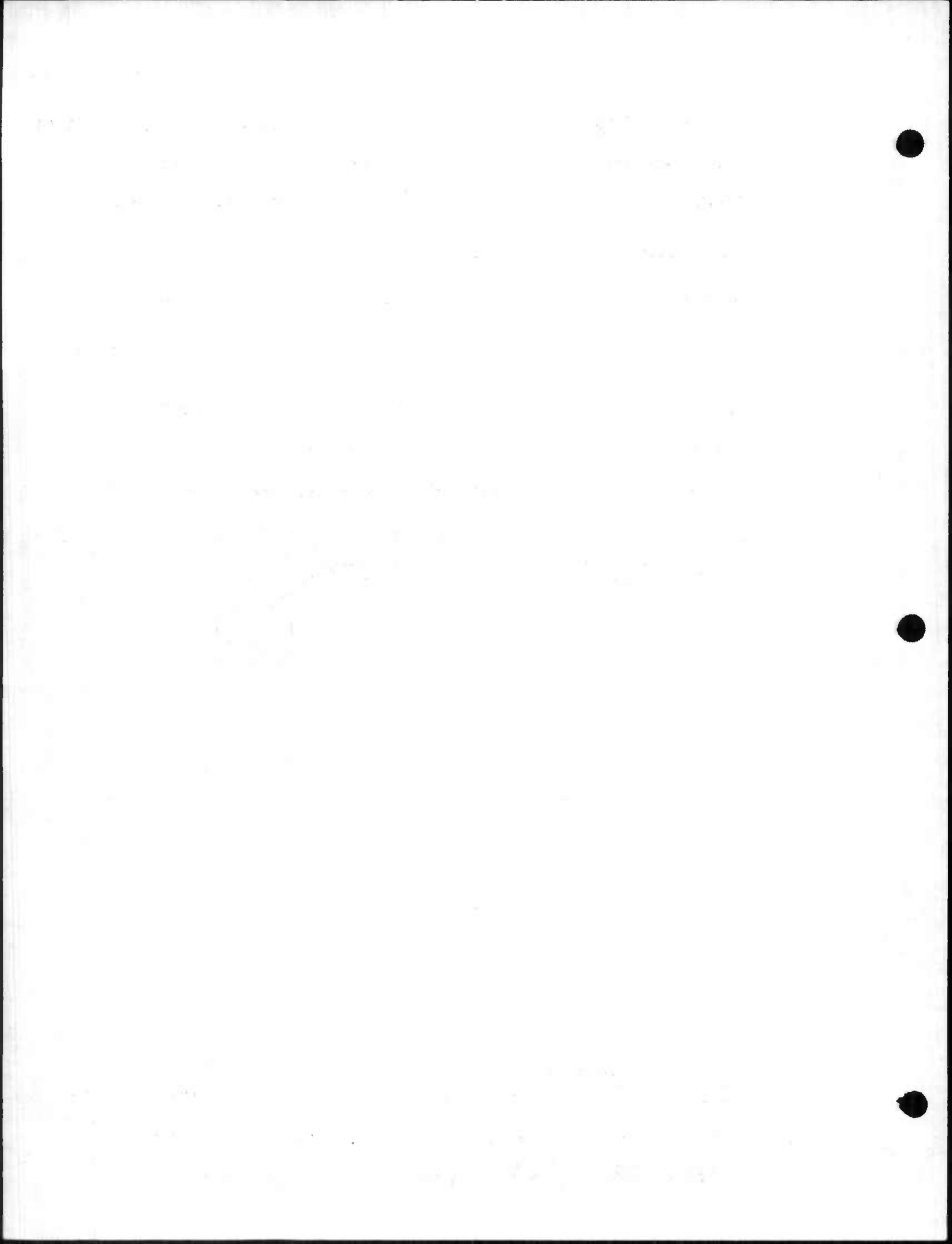
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06427

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |  |  |  |   |  |
|---|--|--|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>John Kocopy</b>   |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>17</b> Year <b>1997</b>  |  |  |  | 3. Time of Death<br><b>2040 P</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Union Hospital of Cecil County</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Elkton</b>   |  |  |  | 4c. County of Death<br><b>Cecil</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>182-10-2338</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>June 1, 1910</b>             |  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>                             |  |
|   | Usual Residence of Decedent  |  |   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Cecil</b>  |  | 10c. City, Town or Location<br><b>Elkton</b>  |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br><b>708 Blue Ball Road</b>  |  |   |  | 10f. Zip Code<br><b>21921</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>                  |  |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify <b>White</b> |  |   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> Collage (1-4 or 5+) <b></b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Assembly worker</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Automotive Industry</b>                                |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Harry Kocopy</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rose Tchorz</b>   |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Rose Ann Eanes/daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>690 Blue Ball Road, Elkton, Maryland 21921</b>  |  |  |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Immaculate Conception Cem.</b>   |  |  |  | 20c. Location - City or Town, State<br><b>Cherry Hill, Maryland</b>                         |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Hicks Home for Funerals, P.A.<br/>103 W. Stockton Street, Elkton, Maryland 21921</b>   |  |  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Large Cell Lymphoma</b><br>Due to (or as a consequence of):<br><br>b. <b>Prostate Carcinoma</b><br>Due to (or as a consequence of):<br><br>c. <b>Hypertension</b><br>Due to (or as a consequence of):<br><br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death<br><br><b>93</b><br><br><b>96</b><br><br><b>20 years</b>   |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypercholesterolemia</b>  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |   |  |
|   |  |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how injury occurred   |  |  |  |   |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  | 29b. Signature and title of certifier<br><br><b>Jose Ma, M.D.</b>  |  |  |  | 29c. License number<br><b>D44716</b>  |  |
|   | 29d. Date signed (Month, Day, Year)<br><b>February 18, 1997</b>  |  |   |  |   |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jose Ma, M.D. 111 West High Street, Elkton, Maryland 21921</b>  |  |   |  |   |  |  |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br><b>FEB 20 1997</b>  |  |   |  | 32. Registrar's Signature<br>  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06428

Reg. No.

|  |  |   |   |  |  |   |  |  |
|--|--|---|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Albert Ritchie Kelly</b>  |   |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>18</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>8:00 pm</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>5309 Emerald Drive</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Sykesville</b>  |   | 4c. County of Death<br><b>Carroll County</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-18-5712</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 6, 1923</b>   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |
|  | Usual Residence of Decedent  |   |   |  |  |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Carroll</b>   |  | 10c. City, Town or Location<br><b>Sykesville</b>   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|  | 10e. Street and Number<br><b>5309 Emerald Drive</b>  |   |   |  | 10f. Zip Code<br><b>21784</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerical</b>   |   | 16b. Kind of Business/Industry<br><b>Records Management</b>  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>William Kelly</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mabel Crowley</b>  |   |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Ruth C. Kelly (Wife)</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5309 Emerald Drive Sykesville, MD 21784</b>  |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)      |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>2/19/97 Owings Mills, MD</b>   |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Brian L. Haight</b>  |   |   |  | 22. Name and Address of Facility<br><b>HAIGHT FUNERAL HOME &amp; CHAPEL (Box 195)<br/>Sykesville, MD 21784 (410)-7951400</b>   |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Metastatic Prostate CA</b> |   |   |  |  |   |  | Approximate Interval Between Onset and Death<br><b>4 yes</b>                                   |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |  |  |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CCPD</b>  |  |   |   |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Flavio Kruter</b>   |   | 29c. License number<br><b>035398</b>             |  | 29d. Date signed (Month, Day, Year)<br><b>2/19/97</b>                                       |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Flavio Kruter, M.D. 684 A Poole Rd. Westminster, MD 21157</b>   |  |   |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 20 1997</b>  |  | 32. Registrar's Signature<br><b>J. A. Anderson-Randall</b>  |   |  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06430

|   |   |  |   |  |  |   |  |  |
|---|---|--|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Irene Catherine Kern</b>   |  |   |  | 2. Date of Death<br>Month <b>Feb.</b> Day <b>17</b> Year <b>1997</b>   |   | 3. Time of Death<br>Approx. <b>3:09 p.m.</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Golden Age Guest Home</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Sykesville</b>  |   | 4c. County of Death<br><b>Carroll</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-01-0502</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>79 Yrs.</b>   |   | 8. Date of Birth (Month, Day, Year)<br><b>June 14, 1917</b>                                    |  |
|   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Carroll</b>   |  | 10c. City, Town or Location<br><b>Westminster</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by<br>Funeral Director  | 10e. Street and Number<br><b>920 Burning Tree Court</b>   |  |   |  | 10f. Zip Code<br><b>21158</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+) <b>College</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>owner/operator</b>                |  | 16b. Kind of Business/Industry<br><b>grocery store</b>   |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Emerson Allison</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Daisey Mac Lawyer</b>  |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>John Kern, son</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>920 Burning Tree Ct., Westminster, MD 21158</b>  |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Westminster Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Westminster, MD</b>  |   | 20d. Date<br><b>2/21/97</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Katherine Pritts - Switzer</b>  |  |   |  | 22. Name and Address of Facility<br><b>Pritts Funeral Home &amp; Chapel<br/>412 Washington Rd., Westminster, MD 21157</b>  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Chronic Obstructive Pulmonary Disease</b><br>Due to (or as a consequence of):<br><b>b. Cerebrovascular Disease</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |   |  |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |  |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |   |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year) |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |   |  |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |  |   |  |  |
| 29b. Signature and title of certifier<br><b>Patrick A. Turnos</b>   |   |  |   | 29c. License number<br><b>D20806</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2/18/97</b>                                       |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Patrick A. Turnos, MD 1425 Liberty Rd ELKERSBURG MD 21754</b>  |   |  |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 19 1997</b>   |   |  |   | 32. Registrar's Signature<br><b>John A. Anderson-Randall</b>                 |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The few requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

97 06431

## Certificate of Death

Reg. No.

|  |  |  |   |                                |   |  |  |  |
|--|--|--|---|--------------------------------|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>NOEL MICHAEL LEVERITT  |  |   |                                | 2. Date of Death<br>Month Day Year<br>FEB. 15, 1997   |  | 3. Time of Death<br>8:05AM   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>HOLY CROSS HOSPITAL  |  |   |                                | 4b. City, Town, or Location of Death<br>SILVER SPRINGS  |  | 4c. County of Death<br>MONTGOMERY  |  |
| Funeral<br>Director  | 5. Social Security Number<br>434-88-3316   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>44 Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>Feb. 22, 1952 |  | 9. Birthplace (State or Foreign Country)<br>Arkansas |
|  | Usual Residence of Decedent  |  |   |                                |   |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland   |  | 10b. County<br>Prince George's  |                                | 10c. City, Town or Location<br>Camp Springs   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br>6908 Berkshire Drive   |  |   |                                | 10f. Zip Code<br>20746  |  | 10g. Citizen of What Country?<br>United States of America                                      |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>3  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Operator                             |                                | 16b. Kind of Business/Industry<br>Construction Cleaning Service   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Noel Mitchel Leveritt   |  |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Marsella Fay   |  |  |  |
|  | 19e. Informant's Name/Relationship (Type, Print)<br>Marsella F. Leveritt /Mother   |  |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>211 E. Sims Street, Canton, Mississippi 39046  |  |  |  |
|  | 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Natchez Trace Cemetery  |                                | Date<br>February 19, 1997   |  | 20c. Location - City or Town, State<br>Madison, Mississippi                                    |  |
|  | 21. Signature of Funeral Service Licensee<br>#M00690<br>Howard A. Carson   |  | 22. Name and Address of Facility<br>Nowell-Flippin Funeral Home, Inc.<br>P.O. Box 71, Canton, Mississippi 39046                                   |                                |   |  |  |  |
|  | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Arteriosclerotic Cardiovascular Disease</u><br>Due to (or as a consequence of):<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |                                |   |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |                                |   |  |  |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |                                |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |   |                                |   |  |  |  |
| To Be Completed by Physician/Medical Examiner  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                                |   |  |  |  |
|  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |                                |   |  |  |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |                                |   |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28e. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |                                |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |                                |   |  |  |  |
| Physician<br>/Medical<br>Examiner  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |                                |   |  |  |  |
|  | 29b. Signature and title of certifier<br>Theodore M. King  |  |   |                                | 29c. License number<br>O.C.M.E  |  | 29d. Date signed (Month, Day, Year)<br>FEB. 16, 1997   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201  |  |   |                                |   |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br>FEB 20 1997   |  | 32. Registrar's Signature<br>John Davidson Randall  |                                |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06432

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |
|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>LUCY ELIZABETH LORD</b>  |  | 2. Date of Death<br>Month <b>FEB</b> Day <b>16</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>10:55PM</b>   |
| 4a. Facility Name (If not institution, give street and number)<br><b>MEMORIAL HOSPITAL</b>  |  | 4b. City, Town, or Location of Death<br><b>EASTON</b>   |  | 4c. County of Death<br><b>TALBOT</b>   |
| 5. Social Security Number<br><b>218-05-9613</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>MAR. 5, 1919</b> |  |
| 9. Birthplace (State or Foreign Country)<br><b>PENNSYLVANIA</b>   |  | Usual Residence of Decedent   |  |  |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>TALBOT</b>   | 10c. City, Town or Location<br><b>EASTON</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 10e. Street and Number<br><b>28535 EDMERE ROAD</b>  |  | 10f. Zip Code<br><b>21601</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>Collega (1-4 or 5+)</b>   |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>   |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>ARCHIE MARINE</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>KATIE COLLINS</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ROBERT F. LORD, SR.</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>28535 EDMERE ROAD, EASTON, MD 21601</b>   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>JR. ORDER CEMETERY</b>   |  | 20c. Location - City or Town, State<br><b>2-19-97 PRESTON, MD</b>  |
| 21. Signature of Funeral Service Licensee<br><b>M. E. Newnam</b>  |  | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME<br/>200 S. HARRISON ST., EASTON, MD</b>  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Sepsis, bacterial</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Skin excoriations, decubiti</b><br><br>c.<br>Dua to (or as a consequence of):<br><br>d.<br>Dua to (or as a consequence of): |  | Approximate Interval Between Onset and Death<br><b>48 hrs.</b>  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br><b>M</b>                            | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><b>David H Smith</b>   |  | 29c. License number<br><b>D39887</b>   |
| 29d. Date signed (Month, Day, Year)<br><b>2/18/97</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DAVID H. SMITH, M.D., 509 IDLEWILD AVENUE, EASTON, MD 21601</b>  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 18 1997</b>   |  | 32. Registrar's Signature<br><b>Davidson-Randall</b>  |  |  |

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06433

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Nicholas Avery Lewis</b>   |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>5</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>6:25 p.m.</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Shady Grove Adventist</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Rockville</b>   |  | 4c. County of Death<br><b>Montgomery</b>   |
| 5. Social Security Number<br>-----  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>Yrs. -----  | If Under 1 Year<br>Months ----- Days -----   | If Under 24 Hrs.<br>Hours ----- Min. -----   | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 5 1997</b>  |
| 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |   |  |  |  |
| Usual Residence of Decedent   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |
| 10a. State<br>-----   | 10b. County<br>-----   | 10c. City, Town or Location<br>-----  |  |  |  |
| 10e. Street and Number<br>-----   |  | 10f. Zip Code<br>-----  |  | 10g. Citizen of What Country?<br>-----   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: -----  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: ----- |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) ----- College (1-4or 5+) -----   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   |  | 16b. Kind of Business/Industry   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Thomas Allan Lewis</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lori Lynn Lazarchick</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Lori Lazarchick / mother</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>19328 Liberty Heights Lane, Germantown, MD</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) -----   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Boyd's Presbyterian</b>  |  | 20c. Location - City or Town, State<br><b>2/22 Boyd's, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Hilton Funeral Home<br/>Barnesville, MD 20838</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; align-items: center;"> <div style="font-size: 3em; margin-right: 10px;">{</div> <div> <p><b>x present rupture of membranes</b><br/>Due to (or as a consequence of):</p> <p><b>x severe prematurity</b><br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____<br/>Due to (or as a consequence of):</p> </div> </div> |  |   |  |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|   |  |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|   |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) ----- |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)<br>-----  | 28b. Time of Injury<br>M -----   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | 28d. Describe how injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>33350</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2-5-97</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JONATHAN ELIAS, MD, 9711 MED. CTR. DR., ROCKVILLE, MD 20850</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 08 1997</b>   |  |   |  |  |  |

State Registrar





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State of Maryland / Department of Health and Mental Hygiene

97 06434

Items: 7, 8, 17 per infor. G-748 6/25/97 dh

## Certificate of Death

Reg. No.

|  |   |  |  |   |   |   |  |   |  |  |
|--|---|--|--|---|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Christopher Philip Lewis</b>   |  |  |   |   |   | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 9, 1997</b>  |   | 3. Time of Death<br><b>6:35 p.m.</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Shady Grove Adventist</b>  |  |  |   |   |   | 4b. City, Town, or Location of Death<br><b>Rockville</b>   |   | 4c. County of Death<br><b>Montgomery</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br>-----  |  | 6. Sex<br><b>XXM</b> 2 <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>Yrs. <b>5</b>   |   | 8. Date of Birth (Month, Day, Year)<br><b>2/9/97</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |
|  | Usual Residence of Decedent   |  |  |   |   |   |  |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Montgomery</b>   |   | 10c. City, Town or Location<br><b>Rockville</b>   |   |  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>Shady Grove Adventist Hospital</b>   |  |  |   | 10f. Zip Code<br><b>20850</b>   |   | 10g. Citizen of What Country?  |   |  |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) |   |   |  | 16b. Kind of Business/Industry  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Thomas Allan Lewis</b>  |  |  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lori Lynn Lazarchick</b>   |   |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lori Lynn Lazarchick/mother</b>  |  |  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>19328 Liberty Heights Ln, Germantown. MD</b> |   |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Boyd's Presbyterian</b>                                       |   | Date<br><b>2/22</b>   |   | 20c. Location - City or Town, State<br><b>Boyd's, MD</b>   |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |  |   | 22. Name and Address of Facility<br><b>Hilton Funeral Home 20838 22111 Beallsville Rd. Barnesville, MD</b>  |   |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Prematurity</b><br>Due to (or as a consequence of):<br><b>b. Premature Rupture of membranes</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |  |   |   |   |  |   |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |   |   |   |  |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year) |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how Injury occurred                                       |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |   |   |   |  |   |  |  |
| 29b. Signature and title of certifier<br>  |   |  |  |   |   | 29c. License number<br><b>D38315</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2-9-97</b>                    |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David E. Sherman MD, 9711 Medical Center Dr Rockville, MD 20850</b>   |   |  |  |   |   |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 08 1997</b>  |   |  |  |   |   |   |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit




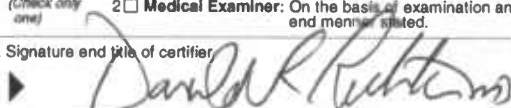
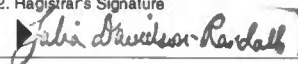
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06435

|                                     |  |   |  |  |  |  |   |   |  |  |
|-------------------------------------|--|---|--|--|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>FREDERICK GREIG LONDON</b>  |   |  |  |  |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>20</b> Year <b>1997</b>                    |   | 3. Time of Death<br><b>6:28 AM</b>   |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>GARRETT COUNTY MEMORIAL HOSPITAL</b>  |   |  |  |  |  | 4b. City, Town, or Location of Death<br><b>OAKLAND</b>                                      |   | 4c. County of Death<br><b>GARRETT</b>  |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>212-03-4242</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>SEPT 28, 1909</b>                                 |   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  |
|                                     | Usual Residence of Decedent  |   |  |  |  |  |   |   |  |  |
| To Be Completed by Funeral Director | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>GARRETT</b>  |  | 10c. City, Town or Location<br><b>MT. LAKE PARK</b>  |  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|                                     | 10e. Street and Number<br><b>408 "K" STREET</b>  |   |  |  | 10f. Zip Code<br><b>21550</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |  |
|                                     | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WW II</b><br>If Yes, Give Year or Dates: <b>KOREA</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |  |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collega (1-4 or 5+)   |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MEAT CUTTER</b>  |  |   | 16b. Kind of Business/Industry<br><b>GROCERY</b>                        |  |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>WILLIAM E. LONDON</b>  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>BLANCHE ELLA DAWSON</b>  |  |   |   |  |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>ADA A. LONDON - WIFE</b>  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>408 K ST. MT. LAKE PARK, MD 21550</b>  |  |   |   |  |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>PLEASANT VALLEY CEMETERY</b>  |  | Date<br><b>2/22</b>  |  | 20c. Location - City or Town, State<br><b>OAKLAND, MARYLAND</b>                             |   |  |  |
|                                     | 21. Signature of Funeral Service Licensee<br> <b>MOO167</b>  |   |  |  | 22. Name and Address of Facility<br><b>P.O. BOX 243<br/>DURST FUNERAL HOME - OAKLAND, MD 21550</b>   |  |   |   |  |  |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>e. <b>Acute myocardial infarction</b><br>Due to (or as a consequence of):<br>b. <b>pulmonary edema, CHF</b><br>Due to (or as a consequence of):<br>c. <b>chronic obstructive pulmonary disease</b><br>Due to (or as a consequence of):<br>d. <b>Atherosclerotic cardiovascular disease</b> |   |  |  |  |  |   |   |  |  |
|                                     | Approximate Interval Between Onset and Death<br><b>12h</b><br><b>3 1/2 d</b><br><b>YRS</b><br><b>YRS</b>   |   |  |  |  |  |   |   |  |  |
| Physician<br>/Medical<br>Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>chronic renal insufficiency</b>   |   |  |  |  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|                                     |  |   |  |  |  |  |   |   | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|                                     |  |   |  |  |  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA      Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |   |  |  |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |
|                                     |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |   |  |  |
|                                     | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |  |  |  |  |   |   |  |  |
|                                     | 29b. Signature and title of certifier<br>   |   |  |  | 29c. License number<br><b>D30035</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2/20/97</b>                                       |   |  |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Donna R. Richter 1573 Memorial Drive OAKLAND MD 21550</b>   |   |  |  |  |  |   |   |  |  |
|                                     | State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>FEB 21 1997</b> |  | 32. Registrar's Signature<br> |  |  |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06436

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SR. ROSE CATHERINE E. LUTENDER, SND

2. Date of Death

FEBRUARY 11, 1997

3. Time of Death

6:20 a.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

ST. CATHERINE'S NURSING CENTER

4b. City, Town, or Location of Death

EMMITSBURG

4c. County of Death

FREDERICK

5. Social Security Number

579-68-0887

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAY 25, 1905

9. Birthplace (State or Foreign Country)

MASS.

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

FREDERICK

10c. City, Town or Location

EMMITSBURG

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

331 S. SETON AVE.

10f. Zip Code

21727

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

SISTER OF  
NOTRE DAME

17. Father's Name (First, Middle, Last)

HENRY LUTENDER

18. Mother's Name (First, Middle, Maiden Surname)

MARY A. McCORMICK

19a. Informant's Name/Relationship (Type, Print)

SR. MARY ADELE WHITE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

333 S. SETON AVE., EMMITSBURG, MD. 21727

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

SISTERS OF NOTRE DAME 2/14/97 ELLICOTT CITY, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

John M. Skiles

22. Name and Address of Facility

SKILES FUNERAL HOME  
210 W. MAIN ST., EMMITSBURG, MD. 2172723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Acute Myocardial infarction  
Due to (or as a consequence of):

3 hrs

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Severe Coronary artery disease  
Due to (or as a consequence of):

3 yrs

c. Valvular Heart Disease  
Due to (or as a consequence of):

20 yrs

d. Congestive Heart Failure  
Hypertension10 yrs  
30 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Osteoporosis,  
Hypertension  
Benign cerebral.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Bonita Krenpel Fortier DO

29c. License number

H 44037

29d. Date signed (Month, Day, Year)

FEBRUARY 11, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Bonita Krenpel Fortier DO

310 S. Seton Avenue  
Emmitsburg, MD 21727

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

John A. Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06437

## Certificate of Death

Reg. No.

|   |  |   |   |   |  |   |   |   |  |
|---|--|---|---|---|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Libby Leipzig</b>   |   |   |   | 2. Date of Death<br>Month <b>February</b> Day <b>17</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>11:25 PM</b>                                     |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SUBURBAN HOSPITAL</b>   |   |   |   | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>  |   | 4c. County of Death<br><b>MONTGOMERY</b>                                |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>143-07-0871</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>02/29/1912</b>                | 9. Birthplace (State or Foreign Country)<br><b>PENNSYLVANIA</b> |  |
|   | Usual Residence of Decedent  |   |   |   | 10a. State<br><b>MARYLAND</b>  |   | 10b. County<br><b>MONTGOMERY</b>  |   | 10c. City, Town or Location<br><b>BETHESDA</b> |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   | 10e. Street and Number<br><b>5225 POOKS HILL ROAD</b>  |   | 10f. Zip Code<br><b>20814</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b> |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PERSONNEL MANAGER</b>             |   | 16b. Kind of Business/Industry<br><b>STATE GOVERNMENT</b>  |   |   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>BENJAMIN BLACK</b>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY BIZAR</b>   |   |   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>MARTA LEIPZIG (DAUGHTER)</b>  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8224 WATTS MINE TERRACE POTOMAC, MARYLAND 20854</b>                                      |   |   |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>KING SOLOMON CEMETERY</b>  |   | 20c. Location - City or Town, State<br><b>CLIFTON, NEW JERSEY</b>  |   | 20d. Date<br><b>2/19/97</b>   |   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   |   |   | 22. Name and Address of Facility<br><b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br/>1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852</b>   |   |   |   |  |
|   | 23. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |   |  |   |   |   |  |
|   | Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Hypertensive Heart Disease with LV</b> 2 weeks<br>Due to (or as a consequence of): <b>failure + pulmonary disease</b><br>b. <b>Hypertension</b> 10 yrs.<br>Due to (or as a consequence of): <b>pulmonary Hypertension</b><br>c. _____<br>Due to (or as a consequence of): _____<br>d. _____ |   |   |   |  |   |   |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Kyphosis of Thorax</b><br><b>Aspiration Pneumonia</b><br><b>Chronic Atrial Fibrillation</b>   |   |   |   |  |   |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)                      |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred                               |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>[Signature]</i> |   | 29c. License number<br><b>011921</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/18/97</b>                                       |   |   |  |
| 30. Name and address of person who completed cause of death (item 23e) (Type, Print)<br><b>John A. Galotto, MD, 5225 Pooks Hill Rd Suite #1, Bethesda, MD</b>   |  |   |   |   |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 19 1997</b>   |  |   |   | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06438

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marie Ann Lee

2. Date of Death

February 9, 1997

3. Time of Death

10:18 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

215-42-4009

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

46 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 19, 1950

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5720 Sugar Maple Ct., B-21

10f. Zip Code

21701

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laundry

16b. Kind of Business/Industry

Nursing Home

17. Father's Name (First, Middle, Last)

Sterling T. Harris

18. Mother's Name (First, Middle, Maiden Surname)

Frances B. Bowens

19a. Informant's Name/Relationship (Type, Print)

Charles Lee, Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5720 Sugar Maple Ct., B-21 / Frederick, Md. 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Centerville Cemetery

Date

2-13-97

20c. Location - City or Town, State

Centerville, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stauffer Funeral Home

1621 Opossumtown Pike/ Frederick, Md. 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

3d

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. massive intra-abdominal tumor

7d

Due to (or as a consequence of):

c. Recurrent Ovarian carcinoma

2 mo

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 14626

29d. Date signed (Month, Day, Year)

Feb 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. R. A. Petersen 501 W 7th St Frederick MD 21701

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06439

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BETTIE B. LEADMAN

2. Date of Death

Month

Day

Year

FEB.

13, 1997

6:50 pm

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

Takoma Park

Montgomery

5. Social Security Number

578-09-0155

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

July 22, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

Maryland

Prince George's

Hyattsville

☐ Yes ☒ No

10e. Street and Number

1505 Jefferson Street

10f. Zip Code

20782

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

General Accounting

Office U.S. Government

17. Father's Name (First, Middle, Last)

Ralph H. Burdette

18. Mother's Name (First, Middle, Maiden Surname)

Susan T. Dalrymple

19e. Informant's Name/Relationship (Type, Print)

Martha B. Strube/ Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4998 Battery Lane #310 Bethesda, Maryland 20814-4959

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematorium or other place)

February 18, 1997

Date

20c. Location - City or Town, State

Montgomery Crematorium Inc.

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M00335

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/

Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue

Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypovolemic Shock

Due to (or as a consequence of):

b. Ruptured Aortic Aneurysm

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☐ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D41089

29d. Date signed (Month, Day, Year)

2/14/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fernando L. Capetone Washington Adventist Hospital, Takoma Park MD 20912

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

State

Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06440

## Certificate of Death

Reg. No.

|   |  |   |  |                                      |  |  |   |   |  |  |
|---|--|---|--|--------------------------------------|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>LEON LEVY</b>   |   |  |                                      | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 15, 1997</b>   |  |   |   | 3. Time of Death<br><b>7:20AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>HOLY CROSS HOSPITAL</b>   |   |  |                                      | 4b. City, Town, or Location of Death<br><b>SILVER SPRING</b>   |  |   |   | 4c. County of Death<br><b>MONTGOMERY</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>094-12-8086</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |                                      | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>07/21/1922</b>                                    |   | 9. Birthplace (State or Foreign Country)<br><b>PENNSYLVANIA</b>                                |  |
|   | Usual Residence of Decedent  |   |  |                                      |  |  |   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MARYLAND</b>  |   | 10b. County<br><b>MONTGOMERY</b>   |                                      | 10c. City, Town or Location<br><b>SILVER SPRING</b>  |  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>10308 LESLIE STREET</b>   |   |  |                                      | 10f. Zip Code<br><b>20902</b>  |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>                                       |   |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b> |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>4</b>   |   |  |                                      | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PHARMACIST</b>  |  |   | 16b. Kind of Business/Industry<br><b>DRUG STORE</b>                     |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>WILLIAM LEVY</b>   |   |  |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>IDA ELKIN</b>  |  |   |   |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>PEARL LEVY</b>  |   |  |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10308 LESLIE ST., SILVER SPRING, MARYLAND 20902</b>                                      |  |   |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>JUDEAN MEMORIAL GARDENS</b>   |                                      | Date<br><b>02/16</b>   |  | 20c. Location - City or Town, State<br><b>NORBECK, MARYLAND</b>                             |   |  |  |
|   | 21. Signature of Funeral Service Licensing<br><i>Frank A. Stone</i>  |   |  |                                      | 22. Name and Address of Facility<br><b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br/>1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852</b>  |  |   |   |  |  |
|   | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Carcinoma of the Pancreas</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>f.<br>Due to (or as a consequence of):<br>g.<br>Due to (or as a consequence of):<br>h.<br>Due to (or as a consequence of): |   |  |                                      |  |  |   |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |  |                                      |  |  |   |   |  |  |
| To Be Completed by Physician/Medical Examiner   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |                                      |  |  |   |   |  |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |                                      |  |  |   |   |  |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |                                      |  |  |   |   |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |                                      |  |  |   |   |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)   |                                      | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how Injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |                                      |  |  |   |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |                                      |  |  |   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |                                      |  |  |   |   |  |  |
| 29b. Signature and title of certifier<br><i>Israel Spector MD</i>   |  |   |  | 29c. License number<br><b>D11200</b> |  | 29d. Date signed (Month, Day, Year)<br><b>Feb 15, 1997</b> |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Israel Spector MD 12001 Fenara Avenue Wheaton Md. 20906</b>  |  |   |  |                                      |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 18 1997</b>   |  | 32. Registrar's Signature<br><i>John Davidson-Rodella</i> |  |                                      |  |  |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06441

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

NEWMAN

P

LYNN

2. Date of Death

Month Day Year

FEBRUARY 11 1997

3. Time of Death

1836

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

577-07-1405

6. Sex

M 2 F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 3, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

Yas 2 No

10e. Street and Number

511 S. Frederick Avenue

10f. Zip Code

20877

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Navar Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yas 2 No

If Yas, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No)

If Yas, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yas 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Drug Store

17. Father's Name (First, Middle, Last)

Newman E. Lynn

18. Mother's Name (First, Middle, Maiden Summa)

Amy C. Peters

19a. Informant's Name/Relationship (Type, Print)

Vincent Lynn (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

464 W. Deer Park Rd., Gaithersburg, MD 20877

20a. Method of Disposition

X Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Potomac Meth Ch. Cem.

Date

2/15

20c. Location - City or Town, State

Potomac, MD

21. Signature of Funeral Service Licensee

George R. Brundage

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.

ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Septic Shock

Due to (or as a consequence of):

Strangulated Right Inguinal Hernia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Peritonitis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Days to weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cardiac Arrhythmias  
Acute myocardial  
Infarction

23b. Did tobacco use contribute to the cause of death?

1 Yas 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yas 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yas 2 No

25. Was case referred to medical examiner?

1 Yas 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yas 2 No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Brajendra Misra, M.D.

29c. License number

D29816

29d. Date signed (Month, Day, Year)

February 11, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brajendra Misra, M.D. 50 Edmonston Drive, Rockville, MD 20850

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06442

|  |   |   |   |                                   |   |  |  |  |
|--|---|---|---|-----------------------------------|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>MONNIE LAVELLE MILLS  |   |   |                                   | 2. Date of Death<br>Month Day Year<br>February 17 1997  |  | 3. Time of Death<br>3:13 PM                                      |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Dorchester Memorial Park  |   |   |                                   | 4b. City, Town, or Location of Death<br>Cambridge   |  | 4c. County of Death<br>Dorchester                                |  |
| Funeral<br>Director  | 5. Social Security Number<br>213-16-8278  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                                   | 7. Age (In yrs. last birthday)<br>Yrs. 94   |  | 8. Date of Birth (Month, Day, Year)<br>Aug 19 1902               |  |
|  | 9. Birthplace (State or Foreign Country)<br>Maryland  |   | 10a. State<br>MD  |                                   | 10b. County<br>Dorchester   |  | 10c. City, Town or Location<br>Crocherson                        |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br>2843 Crocherson Rd.   |                                   | 10f. Zip Code<br>21627  |  | 10g. Citizen of What Country?<br>U.S.A.                          |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7 College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>homemaker                                |                                   | 16b. Kind of Business/Industry<br>own home  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>James Pritchett  |   |   |                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Monnie Sarah Todd  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Hilda Keene-daughter   |   |   |                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1143 Taylors Island Rd., Madison MD 21648  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Dorchester Memorial Park  |                                   | Date<br>2/20  |  | 20c. Location - City or Town, State<br>Cambridge, Maryland       |  |
|  | 21. Signature of Funeral Service Licensee<br>Kenneth R. Thomas Jr.  |   |   |                                   | 22. Name and Address of Facility<br>Thomas Funeral Home PA<br>700 Locust St. Cambridge, MD 21613  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Cardiac arrhythmia Due to (or as a consequence of):<br>b. Respiratory acidosis Due to (or as a consequence of):<br>c. Respiratory insufficiency Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { |   |   |                                   |   |  |  |  |
|  | Approximate interval between Onset and Death<br>2 minutes<br>2 days<br>4 days   |   |   |                                   |   |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |                                   |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |   |   |                                   |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   |                                   |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |   |   |                                   |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |                                   |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of injury<br>M          |   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |   | 28d. Describe how injury occurred |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |   |                                   |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |                                   |   |  |  |  |
| 29b. Signature and title of certifier<br>Mark M. Malkus, MD  |   |   |   | 29c. License number<br>D0050804   |   | 29d. Date signed (Month, Day, Year)<br>2-17-97                                       |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Mark M. Malkus, MD 408 Byrn Street Cambridge, MD   |   |   |   |                                   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 20 1997   |   | 32. Registrar's Signature<br>John Anderson-Randall  |   |                                   |   |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06443

Reg. No.

|   |   |  |   |  |  |  |   |   |  |  |  |  |
|---|---|--|---|--|--|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Tanja Ramm Rowell McKee   |  |   |  |  |  | 2. Date of Death<br>Month February Day 14 Year 1997   |   | 3. Time of Death<br>7:55AM   |  |  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br>6305 River Crescent Drive   |  |   |  |  |  | 4b. City, Town, or Location of Death<br>Annapolis   |   | 4c. County of Death<br>Anne Arundel  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>220-18-8143 A  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>90 Yrs.  |  | 8. Date of Birth<br>Month Day Year<br>Sept 20 1906  |   | 9. Birthplace (State or Foreign Country)<br>New Jersey   |  |  |  |
|   | Usual Residence of Decedent   |  |   |  |  |  |   |   |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>MD  |  | 10b. County<br>Anne Arundel   |  | 10c. City, Town or Location<br>Annapolis   |  |   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |
|   | 10e. Street and Number<br>6305 River Crescent Drive   |  |   |  | 10f. Zip Code<br>21401   |  | 10g. Citizen of What Country?<br>United States  |   |  |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker |  |  | 16b. Kind of Business/Industry<br>Home  |   |  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Carl T. Ramm   |  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Dagny Koren |   |   |  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Margit Rowell (Daughter)  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>17 White Street New York, New York 10013  |  |   |   |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Ft. Lincoln Crematory                        |  | Date<br>2/17/97  |   | 20c. Location - City or Town, State<br>Brentwood, Maryland  |  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br>John M. Taylor Funeral Home, Inc.<br>147 Duke of Gloucester St. Annapolis, MD 21401  |  |   |   |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Astrocystoma</u><br>Due to (or as a consequence of):<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____ |  |   |  |  |  |   |   |  |  | Approximate Interval Between Onset and Death<br>4 months |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|   |   |  |   |  |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |  |  |
|   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                    |   |  |  |  |  |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |  |  |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br>   |   |  |   |  | 29c. License number<br>D48108  |  |   | 29d. Date signed (Month, Day, Year)<br>2/14/97  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>900 Bestgate Rd Suite 300 Annapolis, MD 21401 (Scott Proestel, M.D.)  |   |  |   |  |  |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 18 1997  |   |  | 32. Registrar's Signature<br>   |  |  |  |   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-338-2003.

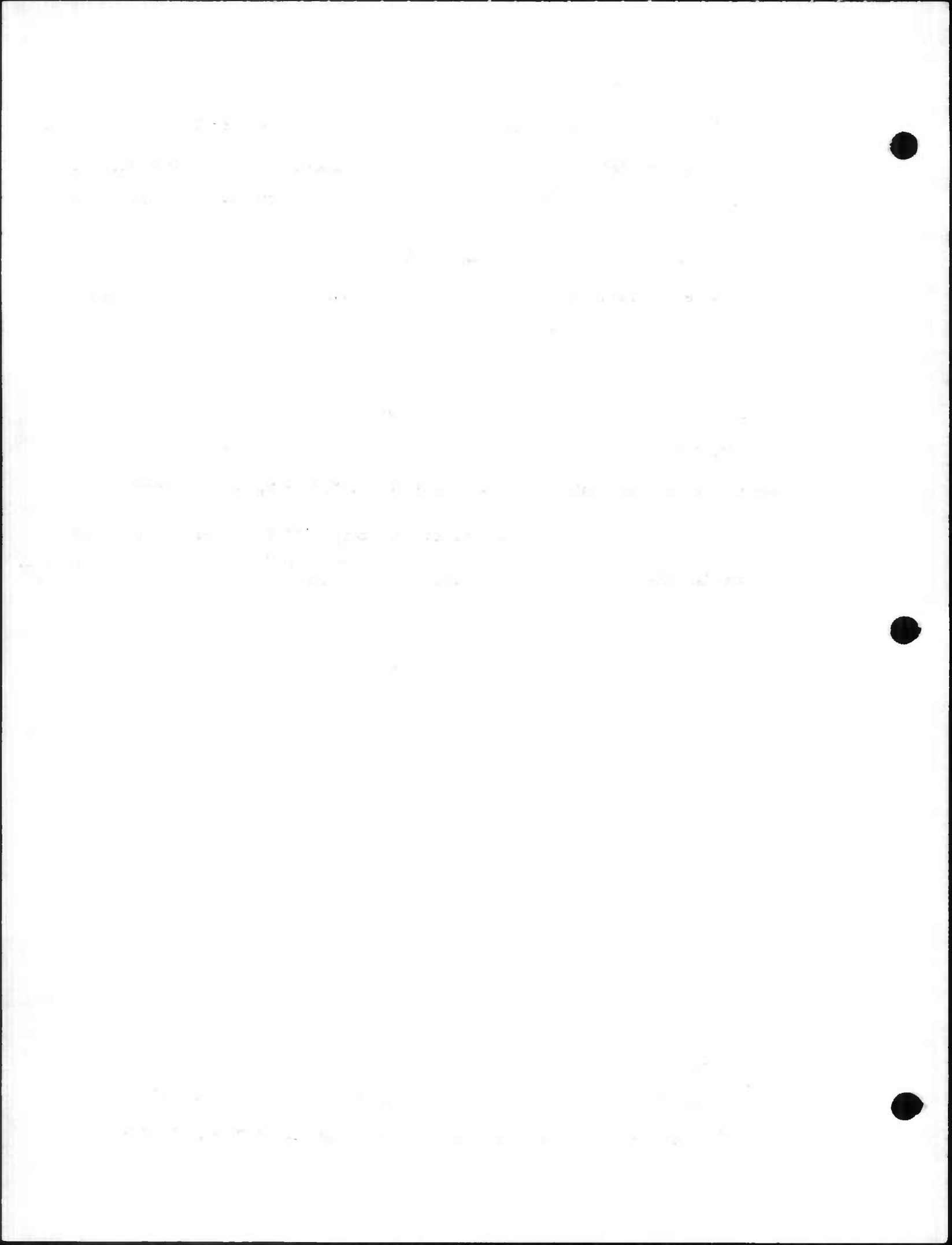
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 15,16a,19a,b per VR/Anatomy Board G-745 3/19/97  
Certificate of Death

97 06444

Reg. No.

|   |  |  |   |   |  |
|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>GLEN C MAINES, III</b>  |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>12</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>4:32pm</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>NORTH ARUNDEL HOSPITAL ASSN GLEN BURNIE ANNE ARUNDEL</b>  |  | 4b. City, Town, or Location of Death<br><b>GLEN BURNIE</b>  |   | 4c. County of Death<br><b>ANNE ARUNDEL</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>578-40-4173</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.  | If Under 1 Year<br>Months Days                                  | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>May 31, 1931</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Dist. Columbia</b>   |   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |  | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Anne Arundel</b>   |
|   | 10c. City, Town or Location<br><b>Millersville</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|   | 10e. Street and Number<br><b>#1 Rol Park Trailer Village</b>   |  | 10f. Zip Code<br><b>21108</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>0</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bricklayer</b>   |
|   | 16b. Kind of Business/Industry<br><b>Construction</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Glen Cleveland Maines, Jr.</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maybelle Edna Lynn</b>   |
|   | 19e. Informant's Name/Relationship (Type, Print)<br><b>PHYLLIS LANGLEY MAINES / WIFE</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b># 1 ROL PARK TRAILER VILLAGE, MILLERSVILLE, MD 21108</b>  |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |   | 20c. Location - City or Town, State<br><b>2/15 Alexandria VA</b>   |
|   | 21. Signature of Funeral Service Licensee<br><i>Melanie Melinda Hagan</i>  |  | 22. Name and Address of Facility<br><b>Advent Funeral &amp; Cremation Services<br/>Falls Church, Virginia 22046</b>   |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |   |  |
| Physician<br>/Medical<br>Examiner   | Immediate Cause (Final disease or condition resulting in death)  |  | a. <b>ACUTE MYOCARDIAL INFARCTION</b>   |   | Approximate Interval Between Onset and Death<br><b>1 HOUR</b>  |
|   | Due to (or as a consequence of):   |  | b. <b>DIABETES MELLITUS</b>   |   | <b>5 YEARS</b>   |
|   | Due to (or as a consequence of):   |  | c. <b>HYPERTENSION</b>  |   | <b>5 YEARS</b>   |
|   | Due to (or as a consequence of):   |  | d.  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |   |  |
| 29b. Signature and title of certifier<br><i>Paul H. Schumacher MD</i>   |  | 29c. License number<br><b>D28221</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>February 13, 1997</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DAVID SCITABRENE, MD 301 HOSPITAL DRIVE GLEN BURNIE MARYLAND</b>   |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 20 1997</b>   |  | 32. Registrar's Signature<br><i>John Davidson</i> <b>21061</b>               |   |   |  |

Baltimore, Maryland 21215-0020  
To the Hospital or Attending Physician: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06445

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred Grace MARONEY

2. Date of Death

Feb. 13, 1997

3. Time of Death

5:00 PM

4a. Facility Name (If not institution, give street and number)

Garrett County Memorial Hospital

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

Funeral  
Director

5. Social Security Number

220-10-2943

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 2, 1918

9. Birthplace (State or Foreign Country)

Vindex, MD

Usual Residence of Decedent

10a. State

MD

10b. County

Garrett

10c. City, Town or Location

Oakland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

615 E. High St.

10f. Zip Code

21550

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Leonard Stark

18. Mother's Name (First, Middle, Maiden Surname)

Lula Stewart

19a. Informant's Name/Relationship (Type, Print)

John R. Maroney

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

840 E. Green St., Oakland, Maryland 21550

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Garrett Co. Mem. Gardens 2/16/97 Oakland, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stewart Funeral Home  
32 S. Second St., Oakland, MD 21550

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

intracerebral bleed (hemorrhagic stroke)

Approximate  
Interval Between  
Onset and Death

18 hour

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

high blood pressure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D15333

29d. Date signed (Month, Day, Year)

2/14/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas G. Johnson, M.D., 311 N. Fourth St Oakland, MD 21550

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10





97 06446

FOR  
STATE  
1 - REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>GERALD EDWARD MATTHEWS  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>FEB 20, 1997  |  | 3. TIME OF DEATH<br>6:42 p. m.  |  |
| 4. SOCIAL SECURITY NUMBER<br>232-62-7283  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>59 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>JUNE 13, 1937   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>West Main Street  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Kitzmiller   |  | 9c. COUNTY OF DEATH<br>Garrett  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br>MD  |  | 10b. COUNTY<br>Garrett   |  | 10c. CITY, TOWN OR LOCATION<br>Kitzmiller   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>West Main Street  |  |  |  | 10f. ZIP CODE<br>21538  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8<br>College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Coalminer   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Coal  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Dewey L. Matthews  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Melinda Rhodes   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Carol Ann Matthews  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P. O. Box 449, Kitmiller, MD 21538   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Kalbaugh Cemetery 2/23/97   |  | 20c. LOCATION — City or Town, State<br>Elk Garden, WV   |  | 20d. DATE<br>2/23/97  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>David A. Burdock Funeral Home<br>P. O. Box 523, Kitzmiller, MD 21538  |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <u>Metastatic esophageal cancer</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>Chronic obstructive pulmonary disease</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <u>Atherosclerotic cardiovascular disease</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate interval Between Onset and Death<br>23 mo<br>yrs<br>yrs |  |  |  |   |  |   | 23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Smoking History - yes</u> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE NOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br>D30035   |  | 29d. DATE SIGNED (Month, Day, Year)<br>02-20-97   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Donald R. Richter, M.D. 1553 Memorial Drive Oakland MD 21550   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 21 1997  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06447

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Patricia Ann McVey

2. Date of Death

Month Day Year  
February 17, 1997

3. Time of Death

3:05 pm

4a. Facility Name (If not institution, give street and number)

104 Plainview Ave

4b. City, Town, or Location of Death

Mt. Airy

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

212-40-5201

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 29, 1940

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Mt. Airy

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

104 Plainview Ave

10f. Zip Code

21771

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Adrian Norris

18. Mother's Name (First, Middle, Maiden Surname)

Mary Souder

19a. Informant's Name/Relationship (Type, Print)

Charles D. McVey / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

104 Plainview Ave, Mt. Airy, Maryland 21771

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Calvary Baptist Cemetery

2/20/97

Data

20c. Location - City or Town, State

Mt. Airy, Maryland.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Olin L. Molesworth P. A. Funeral Home

26401 Ridge Road Damascus, Maryland 20872

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Breast Cancer

Due to (or as a consequence of):

b. metastatic cancer to liver

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 48184

29d. Date signed (Month, Day, Year)

Feb. 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elhamy Eskander MD, 501 W 7th str. Frederick MD 21701

31. Date filed (Month, Day, Year)

FEB 19 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06448

## Certificate of Death

Reg. No.

|   |   |  |  |   |  |
|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Betty Joan McAuliffe</b>   |  | 2. Date of Death<br>Month <b>February</b> Day <b>16</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>12:50 AM</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Frederick</b>   |   | 4c. County of Death<br><b>Frederick</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>154-24-6437</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.   | If Under 1 Year<br>Months Days                        | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 2, 1925</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Australia</b>   |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Frederick</b>  |   | 10c. City, Town or Location<br><b>Frederick</b>  |
|   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |  |
|   | 10e. Street and Number<br><b>2190 Tuscarora Dr.</b>   |  | 10f. Zip Code<br><b>21702</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:      |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                          |   | 16b. Kind of Business/Industry<br><b>own home</b>  |
|   | 17. Father's Name (First, Middle, Last)<br><b>George Henry Browning</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ava Alice Dunne</b>  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Eugene R. McAuliffe / husband</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2190 Tuscarora Dr. / Frederick, Maryland 21702</b> |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mount Olivet Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>Frederick, Maryland</b>  |
|   | 21. Signature of Funeral Service Licensee<br><i>Raymond Peterson</i>  |  | 22. Name and Address of Facility<br><b>Stauffer Funeral Home</b><br><b>1621 Opossumtown Pike / Frederick, Md. 21702</b>                                |   |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line.<br><b>SEPSIS</b><br>Due to (or as a consequence of):<br><b>dehydrated illness</b><br>Due to (or as a consequence of):<br><b>rheumatoid arthritis</b><br>Due to (or as a consequence of):<br><b>cadexia</b>         |  |  |   | Approximate Interval Between Onset and Death<br><b>day</b><br><b>month</b><br><b>year</b><br><b>month</b>  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cerebrovascular accident</b>   |  |  |   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>  |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |   |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |
| 29b. Signature and title of certifier<br><i>Steven Pickens</i>  |   | 29c. License number<br><b>D15804</b>                                       |  | 29d. Date signed (Month, Day, Year)<br><b>2-19-97</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>STEVEN PICKENS</b> |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 21 1997</b>   |   | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>                 |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



97 06449

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LOTTIE AMELIA MYER</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb. 13, 1997  |  | 3. TIME OF DEATH<br>0002 A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>236-22-6247   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>98 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Aug. 31, 1898   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>West Virginia  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Vindabona Nursing Home   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Braddock Heights  |  |
| 9c. COUNTY OF DEATH<br>Frederick   |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Frederick   |  |
| 10c. CITY, TOWN OR LOCATION<br>Braddock Heights  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>6012 Jefferson Boulevard   |  |
| 10f. ZIP CODE<br>21715   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Her home   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Julius Stockert   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Louanna Chandler  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Margaret P. Myer/Daughter-in-law   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>222 Grant Street, Ravenna, Ohio 44266   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Smithsburg Crematory 2/14   |  | 20c. LOCATION — City or Town, State<br>Smithsburg, Maryland  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert E. Dailey</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.<br>1201 NORTH MARKET ST. FREDERICK, MD 21701  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute Myocardial Infarction</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Hypertension</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Alzheimer's disease, Peripheral Vascular disease, Leukemia, Osteoporosis</i>  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Christopher Fleming</i>  |  |  |  | 29c. LICENSE NUMBER<br>037178  |  | 29d. DATE SIGNED (Month, Day, Year)<br>2-14-97   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Christopher Fleming, MD 4014 Mountville Road, Jefferson, Maryland 21715   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 18 1997   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Richard R. Riddell</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06450

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Monica Ann McCormick

2. Date of Death

February 18, 1997

3. Time of Death

7:35 PM

4a. Facility Name (If not institution, give street and number)

9703 Hellingly Place

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

218-38-8638

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 2, 1940 Washington, D.C.

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9703 Hellingly Place

10f. Zip Code

20879

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Dental Assistant

16b. Kind of Business/Industry

Dentistry

17. Father's Name (First, Middle, Last)

Bert Rupert

18. Mother's Name (First, Middle, Maiden Surname)

Melinda Rikard

19a. Informant's Name/Relationship (Type, Print)

Roberta A. DuBois

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

38 Hawthorne Drive Princeton Junction, New Jersey 08550

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory 2/19/97 Alexandria, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Timothy Campbell

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

METASTATIC NONSMALL CELL LUNG CANCER 8

Due to (or as a consequence of):

TO BRAIN

MONTHS

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation  
6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Carolyn B. Hendricks MD

29c. License number

D37236 #300

29d. Date signed (Month, Day, Year)

FEBRUARY 19 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAROLYN B. HENDRICKS MD 9707 MEDICAL CENTER DRIVE ROCKVILLE MD 20815

31. Date filed (Month, Day, Year)

FEB 20 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

6



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06451

## Certificate of Death

Reg. No.

|   |   |   |  |  |   |
|---|---|---|--|--|---|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><i>Alexander Miller, Jr.</i>  |   | 2. Date of Death<br>Month <i>February</i> Day <i>8</i> Year <i>1997</i>  |  | 3. Time of Death<br><i>7:30 P.M.</i>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>Northampton Manor Nursing Home</i>   |   | 4b. City, Town, or Location of Death<br><i>Frederick</i>   |  | 4c. County of Death<br><i>Frederick</i>   |
| Funeral<br>Director                           | 5. Social Security Number<br><i>175-20-9405</i>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>68</i> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><i>May 14, 1928</i> | 9. Birthplace (State or Foreign Country)<br><i>Scotland</i>   |
|   | Usual Residence of Decedent   |   |  |  |   |
| To Be Completed by Funeral Director           | 10a. State<br><i>Pennsylvania</i>   | 10b. County<br><i>Beaver</i>  | 10c. City, Town or Location<br><i>Baden</i>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |
|   | 10e. Street and Number<br><i>West State Street</i>  |   | 10f. Zip Code<br><i>15005</i>  |  | 10g. Citizen of What Country?<br><i>United States</i>   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <i>WWII</i> | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Estimator</i>  |  | 16b. Kind of Business/Industry<br><i>Miscellaneous Metals</i>   |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><i>Alexander Miller, Sr.</i>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Helen Hutt</i>   |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><i>Patricia L. Miller, wife</i>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1512 West State Street Baden, PA 15005</i>   |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Sylvania Hills Mem Park</i>   |  | 20c. Location - City or Town, State<br><i>2/12/97 Rochester, Pennsylvania</i>   |
|   | 21. Signature of Funeral Service Licensee<br><i>James P. Sauer</i>  |   | 22. Name and Address of Facility<br><i>Stauffer Funeral Homes, P.A.<br/>1621 Opossumtown Pike Frederick, MD 21702</i>  |  |   |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>a. Acute Myocardial Infarction</i><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>b. Due to (or as a consequence of):</i><br><i>c. Due to (or as a consequence of):</i><br><i>d. Due to (or as a consequence of):</i> |   |  |  | Approximate Interval Between Onset and Death<br><i>Immediate</i>  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Cerebrovascular accident</i><br><i>Hypertension</i><br><i>Parkinson's Disease</i>  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><i>M</i>   |
|   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   | 29b. Signature and title of certifier<br><i>James E. Decker MD</i>   |  |   |
|   | 29c. License number<br><i>030496 Md.</i>  |   | 29d. Date signed (Month, Day, Year)<br><i>2/9/97</i>   |  |   |
| State<br>Registrar                            | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Francis E. Becker MD; 300 W. 9th St; Frederick, Md 21701</i>   |   |  |  |   |
|   | 31. Date filed (Month, Day, Year)<br><i>FEB 10 1997</i>   |   |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,







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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06453

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Roy R. Madden

2. Date of Death

Month Day Year  
February 15, 1997

3. Time of Death

3:00 PM

4a. Facility Name (If not institution, give street and number)

Manor Care-Chevy Chase

4b. City, Town, or Location of Death

Chevy Chase

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

216-44-9449

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 11, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Florida

10b. County

Palm Beach

10c. City, Town or Location

Greenacres

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5993 LaPinta Blvd.

10f. Zip Code

33463

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Budget Analyst

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Ira P. Madden

18. Mother's Name (First, Middle, Maiden Surname)

Alta Smith

19a. Informant's Name/Relationship (Type, Print)

Carol M. Knott/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3010 Plyers Mill Rd., Kensington, MD 20895

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

Feb. 18, 1997

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee



M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/  
7557 Wisconsin Avenue  
Bethesda, Maryland 20814-3501Bethesda-Chevy  
Chase, Inc.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

e. Artherosclerotic Heart Disease

Years

Due to (or as a consequence of):

b. Metastatic Colon Cancer

Months

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

M

28c. Injury et

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier



29c. License number

D33357

29d. Date signed (Month, Day, Year)

2/18/97

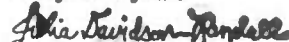
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Lee Jonathan Musher, M.D. 6320 Democracy Blvd., Bethesda, Maryland 20817

31. Date filed (Month, Day, Year)

FEB 20 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06454

|  |   |  |   |  |  |  |  |  |
|--|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Fred Bee Miller</b>  |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>15</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>5:20 A.M.</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Fox Chase Rehabilitation and Nursing Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>   |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-36-7444</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>August 10, 1921</b>                    |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>South Carolina</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Rockville</b>                                  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>317 Lorraine Drive</b>   |  | 10f. Zip Code<br><b>20852</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>                            |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>          |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Engineer</b>  |  | 16b. Kind of Business/Industry<br><b>Electrical</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Fred Conrad Miller</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Julia Bee</b>  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mildred S. Miller/Wife</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>317 Lorraine Drive, Rockville, MD. 20852</b>   |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parklawn Memorial Park</b>   |  | 20c. Location - City or Town, State<br><b>2/18/97 Rockville, Maryland</b>  |  | 20d. Date  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>DeVol Funeral Home</b><br><b>10 East Deer Park Dr., Gaithersburg, MD. 20877</b>   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Pneumonia</b><br>Due to (or as a consequence of):<br>b. <b>Aspiration</b><br>Due to (or as a consequence of):<br>c. <b>Dysphagia</b><br>Due to (or as a consequence of):<br>d. <b>Cerebral hemorrhage</b> |  |   |  |  |  |  |  |
|  | 23b. Approximate Interval Between Onset and Death<br><b>2 weeks</b><br><b>8 months</b><br><b>8 months</b><br><b>8 months</b>  |  |   |  |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b>   |  |   |  |  |  |  |  |
| 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   |  |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 28d. Describe how Injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |  |  |
| 20   | 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>D41881</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>February 15, 1997</b>                  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Allan S. Rogers, M.D., 8630 Fenton Street, # 900, Silver Spring, Maryland 20910</b>  |  |   |  |  |  |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>FEB 19 1997</b>   |  | 32. Registrar's Signature<br>  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06455

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret R. Montgomery

2. Date of Death  
Month Day Year

February 13, 1997

3. Time of Death

3:40 PM

4a. Facility Name (If not institution, give street and number)

3510 Forest Edge Drive

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

325-28-4849

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Aug. 18, 1906

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3510 Forest Edge Drive

10f. Zip Code

20906

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Ralston Montgomery

18. Mother's Name (First, Middle, Maiden Surname)

Laura Raymond

19a. Informant's Name/Relationship (Type, Print)

Stuart W. Kramer / cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9314 Arnon Chapel Road, Great Falls, Virginia 22066

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc.

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/  
7557 Wisconsin Avenue  
Bethesda, Maryland 20814-3501

Bethesda-Chevy Chase, Inc.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Immediate

b. Arteriosclerotic Heart Disease

Due to (or as a consequence of):

3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Lung Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D24543

29d. Date signed (Month, Day, Year)

February 14, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Rossi, M.D. North Leisure World Blvd., Silver Spring, Maryland 20906

31. Date filed (Month, Day, Year)

FEB 20 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06456

Item: 18 per F.H. G-746 4/17/97 reb

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM

2. Date of Death

Month

Day

Year

FEBRUARY 15, 1997

3. Time of Death

1700 PM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

566-18-4705

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUNE 17, 1917

9. Birthplace (State or Foreign Country)

CALIFORNIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

DAMASCUS

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

26116 VIEWLAND DRIVE

10f. Zip Code

20872

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1950-69

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OFFICER

18b. Kind of Business/Industry

U.S. ARMY

17. Father's Name (First, Middle, Last)

WILLIAM J. MCLEAN

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE DONOUGH McDonough

19a. Informant's Name/Relationship (Type, Print)

ROBERT MCLEAN - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8211 TOLLHOUSE RD., ANNANDALE, VA 22003

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARLINGTON NATIONAL CEMETERY 2/28/97 ARLINGTON, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DEMAINE FUNERAL HOMES, INC.

520 S. WASHINGTON STREET

ALEXANDRIA, VA 22314

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Asystole 2° to Hypoxia 2°

Few minutes

Due to (or as a consequence of):

b. pulmonary embolus / heart attack

1 hr

Due to (or as a consequence of):

c. coronary artery disease

Due to (or as a consequence of):

d. atherosclerosis

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

sepsis / Aspiration pneumonia  
chronic obstructive pulmonary disease  
prostate cancer / pulmonary cancer  
Atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

Rashid Nigh

29c. License number

D39372

29d. Date signed (Month, Day, Year)

Feb 16 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RASHID NIGH 344 UNIVERSITY BLVD WEST  
SUITE 324 SILVER SPRING MD 20901

31. Date filed (Month, Day, Year)

FEB 20 1997

32. Registrar's Signature

J. L. Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06457

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

S. Bruce

2. Date of Death

Month

Day

Year

3. Time of Death

9:24

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

117-16-0569

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

May 10, 1926

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4108 Ferrara Drive

10f. Zip Code

20906

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

communications consultant

16b. Kind of Business/Industry

Racal Communications

17. Father's Name (First, Middle, Last)

Steven Mahoney

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Schaeffer

19a. Informant's Name/Relationship (Type, Print)

Lorraine May Mahoney wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4108 Ferrara Drive, Silver Spring, Maryland 20906

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Chesapeake Crematory

Date

2-16-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Carol A. Delo

22. Name and Address of Facility

Rapp Funeral Services, P.A.  
933 Gist Avenue, Silver Spring, Maryland 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. acute myocardial infarction

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 hr.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John Tamber

29c. License number

D08546

29d. Date signed (Month, Day, Year)

Feb 15 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Tamber

5218 Wisconsin Ave

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Julia Davidson-Rodriguez

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10





97 06458

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DOROTHY B. MEIER</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 20, 1997</b>   |  |   |  | 3. TIME OF DEATH<br><b>10:28 P.M.</b>  |   |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>384-03-8609</b>  |  |  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>95</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>August 10, 1901</b>                        |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Beardstown Illinois</b> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Calvert Manor Health Care Center</b>  |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rising Sun</b>  |  |  | 9c. COUNTY OF DEATH<br><b>Cecil</b>   |  |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |   |  |  |   |  |  |
| 10a. STATE<br><b>Maryland</b>  |  |  | 10b. COUNTY<br><b>Cecil</b>  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>Rising Sun</b>  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |  |
| 10e. STREET AND NUMBER<br><b>1881 Telegraph Road</b>   |  |  |  |  |  | 10f. ZIP CODE<br><b>21911</b>   |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                          |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+) <b></b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Home Maker</b>  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>                                    |   |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Thomas J. Bowman</b>   |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Jessie Caldwell</b>   |  |  |   |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Patricia M. McCullough</b>  |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1 Oak Rd. Elkton, Maryland 21911</b>  |  |  |   |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Hillside Cemetery Feb. 2, 97</b>   |  |   |  | 20c. LOCATION — City or Town, State<br><b>Plainwell, Michigan</b>                    |   |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>[Signature]</b> 479  |  |  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Robert T. Jones &amp; Foard, Inc.<br/>122 West Main Street Newark, Delaware 19711</b>  |  |  |   |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |   |  |  |   |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b>   |  |  |  |  |  |   |  |  |   |  |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |   |  |  |   |  |  |
| b. <b>cardiovascular</b>   |  |  |  |  |  |   |  |  |   |  |  |
| c. <b>osteoarthritis</b>   |  |  |  |  |  |   |  |  |   |  |  |
| d.   |  |  |  |  |  |   |  |  |   |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |  |  |   |  |  |   |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>immobilization 2° to c</b>  |  |  |  |  |  |   |  |  |   |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |   |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |  |  |   |  |  |   |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED                                      |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>D54102</b>   |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/20/97</b>                  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>William F. Renzulli M.D. 901 Warburton Rd, Elkton, MD 21921</b>  |  |  |  |  |  |   |  |  |   |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 21 1997</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |  |   |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06459

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Millard William McGee</b>   |  |   |  | 2. Date of Death<br>Month <b>Feb.</b> Day <b>20</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>6:40 AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Golden Age Guest Home</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Sykesville</b>  |  | 4c. County of Death<br><b>Carroll</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>579-10-2370</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb 9, 1913</b>                        |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Carroll</b>  |  | 10c. City, Town or Location<br><b>Westminster</b>                                |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>3731 Turkeyfoot Rd.</b>  |  | 10f. Zip Code<br><b>21158</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>                            |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>          |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th</b> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Carpenter</b>   |  | 16b. Kind of Business/Industry<br><b>Construction</b>  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Millard S. McGee</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Betty Linhoss</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Deborah Dustin (Daughter)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3731 Turkeyfoot Rd. Westminster, MD 21158</b>  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lake View Memorial Park</b>  |  | 20c. Location - City or Town, State<br><b>2/24/97 Sykesville, MD</b>   |  | 20d. Date  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Burrier-Queen Funeral Directors<br/>1212 W. Old Liberty Rd. Winfield, MD 21784</b>  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. PRIMARY DEMENTIA</b><br>Due to (or as a consequence of):<br><b>b. DEGENERATIVE JOINT DISEASE</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |  | Approximate Interval Between Onset and Death<br><b>&gt; 2 yrs</b><br><b>&gt; 10 yrs</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D20806</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2/21/97</b>                            |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>PATRICE TURNER, MD 1425 Liberty Rd Eldersburg MD 21784</b>  |  |   |  | 31. Date filed (Month, Day, Year)<br><b>FEB 21 1997</b>  |  |  |  |
|   | 32. Registrar's Signature<br>   |  |   |  |  |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06460

## Certificate of Death

Reg. No.

|  |  |   |   |   |   |   |  |  |
|--|--|---|---|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Paul Otto Meyer Sr.</b>   |   |   |   | 2. Date of Death<br>Month <b>02</b> Day <b>18</b> Year <b>97</b>  |   | 3. Time of Death<br><b>9:45pm</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>2911 Halter Rd.</b>   |   |   |   | 4b. City, Town, or Location of Death<br><b>Westminster</b>  |   | 4c. County of Death<br><b>CARROLL</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-09-8440</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 19, 1921</b>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |   | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Carroll</b>   |   | 10c. City, Town or Location<br><b>Westminster</b>  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>2911 Halter Rd.</b>  |   | 10f. Zip Code<br><b>21158</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>41-'45</b>   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Welder</b>  |   | 16b. Kind of Business/Industry<br><b>Steel Co.</b>  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Jacob Meyer</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alwine Hoehn</b>  |   |   |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lorraine D. Meyer/Daughter</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2819 Halter Rd. Westminster, MD 21158</b>   |   |   |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Mary's Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>2/23/97 Silver Run, MD</b>  |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>  |   | 22. Name and Address of Facility<br><b>Little's F.H. 34 Maple Ave. Littlestown, PA 17340</b>  |   |   |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.<br><b>Immediate Cause (Final disease or condition resulting in death)</b><br><b>a. ESOPHAGEAL CA</b><br>Due to (or as a consequence of):<br><b>b.</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |   |  |  |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)<br><b>28b. Time of Injury</b><br><b>M</b><br><b>28c. Injury at Work?</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how Injury occurred   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>[Signature]</b> |   | 29c. License number<br><b>D35398</b>            |   | 29d. Date signed (Month, Day, Year)<br><b>2/19/97</b> |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Flavio Kruter, M.D. 684 A Poole Rd Westminster, MD 21157</b>  |  | 31. Date filed (Month, Day, Year)<br><b>FEB 21 1997</b>     |   | 32. Registrar's Signature<br><b>[Signature]</b> |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06461

Reg. No.

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>THOMAS EARL MC NAIR</b>  |   | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>21</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>4:00 AM</b>   |
|  | 4a. Facility Name (If not in Park, give street and number)<br><b>2383 WINDSOR COURT</b>   |   | 4b. City, Town, or Location of Death<br><b>WALDORF</b>  |   | 4c. County of Death<br><b>CHARLES</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>257-12-6970</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.  | If Under 1 Year<br>Months Days                                  | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>APRIL 1, 1923</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>GEORGIA</b>  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MARYLAND</b>   |   | 10b. County<br><b>CHARLES</b>   |   | 10c. City, Town or Location<br><b>WALDORF</b>  |
|  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |  |
|  | 10e. Street and Number<br><b>2383 WINDSOR COURT</b>   |   | 10f. Zip Code<br><b>20602</b>   |   | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:       |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br><b>WHITE</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4or 5+) <b>5+</b>                   |   |  |
|  | 16. Kind of Business/Industry<br><b>UNITED STATES AIR FORCE</b>   |   | 17. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>OFFICER / LT. COL.</b>                   |   |  |
|  | 18. Father's Name (First, Middle, Last)<br><b>ARTHUR MURRY McNAIR</b>   |   | 19. Mother's Name (First, Middle, Maiden Surname)<br><b>MAMIE ELIZABETH PARTRIDGE</b>   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>DANA E. MEILSON / DAUGHTER</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1666 BENT TREE TRAIL OCEAN ISLE BEACH, NC 28469</b> |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ARLINGTON NATIONAL CEM.</b>  |   | 20c. Location - City or Town, State<br><b>ARLINGTON, VIRGINIA</b>  |
|  | 21. Signature of Funeral Service Licensee<br><b>MARK G. BROHAWN M-00053</b>   |   | 22. Name and Address of Facility<br><b>THE HUNTT FUNERAL HOME, INC.<br/>P.O. BOX 156 WALDORF, MARYLAND 20604</b>  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Congestive heart failure</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |   |   |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |   |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>                                 |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred   |   |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |   |   |  |
| 29b. Signature and title of certifier<br><b>AMC Chubb / Dr. Mc</b>   |   | 29c. License number<br><b>02738</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 21, 1997</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>HOWARD M. HAFT, M.D., 700 OLD LINE CTR., #100, WALDORF, MARYLAND 20602</b>  |   |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 1997</b>  |   | 32. Registrar's Signature<br><b>John Davidson-Raschall</b>  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the paper is devoted to a discussion of the

main results of the paper.

2. The second part of the paper is devoted to a discussion of the

main results of the paper.

3. The third part of the paper is devoted to a discussion of the

main results of the paper.

4. The fourth part of the paper is devoted to a discussion of the

main results of the paper.

5. The fifth part of the paper is devoted to a discussion of the

main results of the paper.

6. The sixth part of the paper is devoted to a discussion of the

main results of the paper.

7. The seventh part of the paper is devoted to a discussion of the

main results of the paper.

8. The eighth part of the paper is devoted to a discussion of the

main results of the paper.

9. The ninth part of the paper is devoted to a discussion of the

main results of the paper.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I, 27, 28a, b, d, e, f per MEO G-745

3/21/97 reb  
Certificate of Death

97 06462

Reg. No.

|   |  |  |  |  |  |  |  |   |
|---|--|--|--|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JERSEL N. NORMAN</b>                            |  |  |  | 2. Date of Death<br>Month <b>FEB.</b> Day <b>8,</b> Year <b>1997</b> |  | 3. Time of Death<br><b>0640 AM</b>                       |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>4221 CABIN CREEK ROAD</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>HURLOCK</b>               |  | 4c. County of Death<br><b>DORCHESTER</b>                 |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>238-94-6702</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>41</b> Yrs.   | If Under 1 Year<br>Months Days                                       | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>04/09/1955</b> | 9. Birthplace (State or Foreign Country)<br><b>NORTH CAROLINA</b> |
|   | Usual Residence of Decedent  |  |  |  |  |  |  |   |
| 10a. State<br><b>DELAWARE</b>   |  | 10b. County<br><b>Sussex</b>   |  | 10c. City, Town or Location<br><b>SEAFORD</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |
| 10e. Street and Number<br><b>RR 2 BOX 190-A</b>   |  |  |  | 10f. Zip Code<br><b>19973</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ROOFER</b>   |  | 16b. Kind of Business/Industry<br><b>BUILDING CONSTRUCTION</b>   |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>JESSIE LEE WEBB</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY CHRISTINE NORMAN</b>  |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MARY CHERRY</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>330 HIGHWAY 32 NORTH ROPER, N.C. 27970</b>   |  |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>D.H.F.T.C.I.</b>  |  | Date<br><b>2/14/97</b>   |  | 20c. Location - City or Town, State<br><b>SMYRNA, DELAWARE</b>   |  |   |
| 21. Signature of Funeral Serving Licensee<br>   |  |  |  | 22. Name and Address of Facility<br><b>BENNIE SMITH FUNERAL HOME<br/>P.O. BOX 1687 EASTON, MARYLAND 21601</b>  |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>ACUTE COCAINE AND NARCOTIC INTOXICATION</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>a. b. c. d.</b><br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death                      |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |
|   |  |  |  |  |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |
|   |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>FOUND 2/8/97</b>  |  | 28b. Time of Injury<br><b>found 6:30 M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred<br><b>Unknown</b>               |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Found in house</b>  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>4221 Cabin Creek Rd.<br/>Hurlock, Md.</b>   |  |   |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |   |
| 29b. Signature and title of certifier<br>   |  |  |  | 29c. License number<br><b>O.C.M.E</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>FEB. 9, 1997</b>   |  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dennis J Chute 111 Penn Street, Baltimore, Maryland 21201</b>  |  |  |  |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 19 1997</b>   |  | 32. Registrar's Signature<br>  |  |  |  |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



97 06463

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BETTIE REBECCA NAYLOR</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>Feb</b> DAY <b>17</b> YEAR <b>97</b>   |  | 3. TIME OF DEATH<br><b>9:10 PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-30-6569</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>62</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>March 17, 1934 Md.</b>                                      |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Pleasant View Nursing Home</b>   |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Mt. Airy</b>  |  | 8c. COUNTY OF DEATH<br><b>Carroll County</b>  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Md.</b>  |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |
| 10e. STREET AND NUMBER<br><b>220 West South Street</b>  |  |  |  | 10f. ZIP CODE<br><b>21701</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                               |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>College</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Electronic Assembler</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Air-Pax</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Walter C. Naylor</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mazie Whiton</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Debbie Williams daughter</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>220 West South Street Fredgrier, MD. 21701</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Paul A.M.E. Cemetery Feb. 22 Della, Md.</b>  |  | 20c. LOCATION — City or Town, State   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Gary L. Rollins</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Gary L. Rollins Funeral Home<br/>100 W. All Saints St. Frederick, Md. 21701</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Coronary Artery Disease</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>Hypertension</i><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  | Approximate Interval Between Onset and Death<br><i>1 month</i><br><i>4 years</i>                      |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Cerebrovascular accident</i><br><i>Severe urinary tract infection</i><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                      |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>026899</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/17/97</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Ronald Miller<br/>4 Culwell Drive Mt Airy Md 21771</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 28 1997</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06464

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ann M. Norling

2. Date of Death

Month Day Year  
February 11, 1997

3. Time of Death

6:25 PM

4e. Facility Name (If not institution, give street and number)

Shady Grove Adventist Nursing Center

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-20-7394

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 16, 1923

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8809 Tallyho Trail

10f. Zip Code

20854

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Ralph M. Davis

18. Mother's Name (First, Middle, Maiden Surname)

Mary Sullivan

19a. Informant's Name/Relationship (Type, Print)

Richard V. Norling/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8809 Tallyho Trail, Potomac, Maryland 20854

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place) Date

Montgomery Crematorium, Inc. Feb. 17, 1997

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Raymond

M00198

22. Name and Address of Facility  
Robert A. Pumphrey Funeral Home/Rockville, Inc.  
300 West Montgomery Avenue  
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. urosepsis  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

WKS.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Lastb. cerebrovascular accident  
Due to (or as a consequence of):

YRS.

c. Hypertension  
Due to (or as a consequence of):

YRS

d. Diabetes Mellitus

YRS.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Raymond

29c. License number

D35792

29d. Date signed (Month, Day, Year)

FEBRUARY, 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Swaroop G. Rao, 50 W. Edmonston Dr, R, MD.

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

John L. Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06465

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George Francis Norris

2. Date of Death

Month Day Year

February 17 1997

3. Time of Death

10:41 AM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

577-05-2540

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)

Dec. 22, 1921

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11117 Mitscher Street

10f. Zip Code

20895

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Mechanical Engineer

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Joseph W. Bell

18. Mother's Name (First, Middle, Maiden Surname)

Pauline M. Kienast

19a. Informant's Name/Relationship (Type, Print)

George M. Norris

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 Arborwood Court Sewell, New Jersey 08080

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan Crematory

Date

2/19/97

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Eric S. Scerbo

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Approximate

Interval Between

Onset and Death

Immediate Cause (Final

disease or condition

resulting in death)

a.

Pneumonia

Due to (or as a consequence of):

3d

b.

Interstitial Fibrosis - Pulmonary

Due to (or as a consequence of):

2 yrs

c.

Rheumatoid Arthritis

Due to (or as a consequence of):

10 yrs

d.

Sequently list conditions,

if any, leading to immediate

cause. Enter Underlying

Cause (Disease or injury

that initiated events

resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending2 ☐ Accident investigation3 ☐ Suicide 8 ☐ Could not be4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

1 ☒ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David A. Holden MD Attending

29c. License number

D47791

29d. Date signed (Month, Day, Year)

February 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David A. Holden MD 809 Veis Mill, Rockville MD 20851

31. Date filed (Month, Day, Year)

FEB 19 1997

32. Registrar's Signature

John Davidson-Randall

State

Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





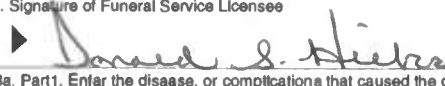
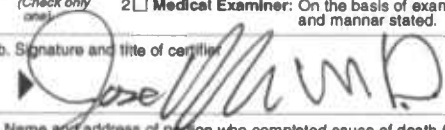
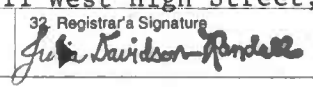
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06466

Reg. No.

|   |   |  |  |  |  |   |   |  |
|---|---|--|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Dorothy Cecilia Osborne</b>                |  |  |  | 2. Date of Death<br>Month <b>February</b> Day <b>19</b> Year <b>1997</b> |   | 3. Time of Death<br><b>0718 A</b>                                       |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>20 Montrose Lane</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Elkton</b>                    |   | 4c. County of Death<br><b>Cecil</b>                                     |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>222-09-3117</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 6. Date of Birth (Month, Day, Year)<br><b>August 29, 1915</b>           |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>                           |  |  |  |  |   |   |  |
| Usual Residence of Decedent   |   |  |  |  |  |   |   |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Cecil</b>  |  | 10c. City, Town or Location<br><b>Elkton</b>   |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number<br><b>20 Montrose Lane</b>   |   |  |  | 10f. Zip Code<br><b>21921</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>                                       |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>  |  |   | 16b. Kind of Business/Industry<br><b>Government</b>                     |  |
| 17. Father's Name (First, Middle, Last)<br><b>John Hall</b>   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edith Fuller</b>   |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Carolyn L. Neff/Niece</b>  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>40 Crestwood Drive, Elkton, Maryland 21921</b>   |  |   |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>R.A. Ferris Company</b>   |  | Date<br><b>2/20/97</b>  |   | 20c. Location - City or Town, State<br><b>West Chester, PA</b>                                 |
| 21. Signature of Funeral Service Licensee<br>   |   |  |  | 22. Name and Address of Facility<br><b>Hicks home for Funerals, P.A.<br/>103 W. Stockton Street, Elkton, Maryland 21921</b>  |  |   |   |  |
| 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>COPD</b><br/>Due to (or as a consequence of):</p> <p>b. <b>Dementia</b><br/>Due to (or as a consequence of):</p> <p>c. <b>Cerebrovascular disease</b><br/>Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> <p><b>20</b></p> <p><b>5</b></p> </div> </div> |   |  |  |  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |  |  |  |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |  |  |  |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Supervised care home</b> |  |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D44716</b>   |  | 29d. Date signed (Month, Day, Year)   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jose Ma, M.D. 111 West High Street, Elkton, Maryland 21921</b>   |   |  |  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 20 1997</b>   |   | 32. Registrar's Signature<br>   |  |  |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

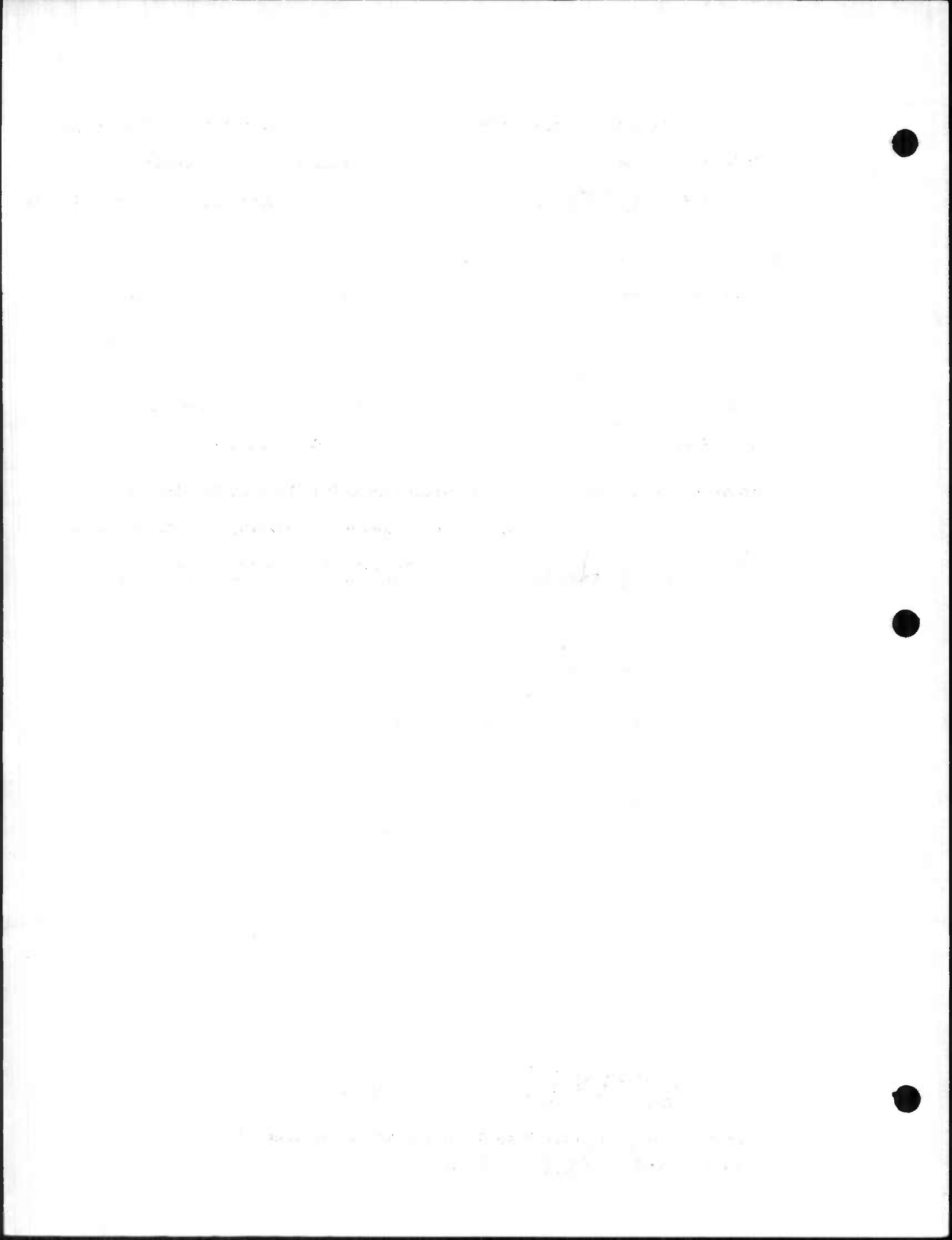
To Be Completed by Physician/Medical Examiner

Dorothy C. Osborne

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06467

Reg. No.

|  |   |   |   |  |  |  |  |  |  |  |
|--|---|---|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Barbara Ellen Parkinson   |   |   |  | 2. Date of Death<br>Month Day Year<br>February 16 1997   |  | 3. Time of Death<br>2:44AM                                 |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Anne Arundel Medical Center   |   |   |  | 4b. City, Town, or Location of Death<br>Annapolis  |  | 4c. County of Death<br>Anne Arundel                        |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>213-34-0889  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>60 Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>April 13 1936       | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |  |
|  | Usual Residence of Decedent   |   |   |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>MD  |   | 10b. County<br>Anne Arundel   |  | 10c. City, Town or Location<br>Annapolis   |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |
|  | 10e. Street and Number<br>1217 Barbud Lane  |   |   |  | 10f. Zip Code<br>21403   |  | 10g. Citizen of What Country?<br>United States             |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8<br>College (1-4or 5+) 8  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker |  |  | 16b. Kind of Business/Industry<br>Home                     |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>James A. Meiklejohn  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Bernice Pearl Hall  |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print) (Husband)<br>Alexander F. Parkinson, Sr.   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1217 Barbud Lane Annapolis, Maryland 21403  |  |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Ft. Lincoln Crematory   |  | Date<br>Feb. 21, 1997  |  | 20c. Location - City or Town, State<br>Brentwood, Maryland |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br>John M. Taylor Funeral Home, Inc.<br>147 Duke of Gloucester St. Annapolis, MD 21401  |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. SUDDEN CARDIAC ARREST<br>Due to (or as a consequence of):<br>b. PROBABLE CORONARY ARTERY DISEASE<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |  |  |  | Approximate Interval Between Onset and Death   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>SEVERE RHEUMATOID ARTHRITIS<br>PROBABLE COLON CANCER  |   |   |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br>   |   | 29c. License number<br>D38328  |  | 29d. Date signed (Month, Day, Year)<br>2/16/97                                       |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Mary Clance, M.D. 180 Admiral Cochrane Drive Annapolis, Maryland 21401   |   |   |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 18 1997   |   | 32. Registrar's Signature<br>   |   |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06468

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lola Rosalie Price

2. Date of Death

Month Day Year  
Feb. 23 1997

3. Time of Death

8:20AM

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

215-26-1984

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 26, 1903

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Little Orleans

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10730 Orleans Road, N.E.

10f. Zip Code

21766

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Clothing Manufacture

17. Father's Name (First, Middle, Last)

Alfred Creek

18. Mother's Name (First, Middle, Maiden Surname)

Mattie Brady

19a. Informant's Name/Relationship (Type, Print)

Lester Price/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10730 Orleans Road, N.E. Little Orleans, MD 21766

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Piney Plains Cemetery

Date

2/26/97

20c. Location - City or Town, State

Little Orleans, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Grove Funeral Home, P.A.  
P.O. Box 368 Hancock, MD 2175023a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. pneumonia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

5 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. lung mass, likely Carcinoma

Due to (or as a consequence of):

unknown

c. pulmonary fibrosis

Due to (or as a consequence of):

20+ yrs

d. chronic obstructive pulmonary disease

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease, supraventricular  
tachycardia, severe congestive heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D43389

29d. Date signed (Month, Day, Year)

2/23/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SUSAN B. BRINKLEY, MD; 11110 ROBINWOOD MEDICAL CAMPUS RD, SUITE 226  
HAGERSTOWN, MD 21742

31. Date filed (Month, Day, Year)

MAR 05 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06469

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Victoria Alexis PIECHOCINSKI

2. Date of Death

February 12, 1997

3. Time of Death

3:45 AM

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

373-50-3124

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

50

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 26, 1946

9. Birthplace (State or Foreign Country)

California

Usual Residence of Decedent

10e. State

California

10b. County

Los Angeles

10c. City, Town or Location

Torrance

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

941 West Carson Street, # 117

10f. Zip Code

90502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Deputy City Clerk

16b. Kind of Business/Industry

City Government

17. Father's Name (First, Middle, Last)

Chester

PIECHOCINSKI

18. Mother's Name (First, Middle, Maiden Surname)

Louise

BEREN

19a. Informant's Name/Relationship (Type, Print)

Thomas L. Baker, Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

941 W. Carson St., # 117, Torrance, Calif. 90502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Hills Memorial Park, Feb. 22, 1997

Date

20c. Location - City or Town, State

Rancho Palos Veres, Calif.

21. Signature of Funeral Service Licenses

Richard E. Yeron

MO0255

22. Name and Address of Facility

Keeney and Basford P.A. Funeral Home

106 East Church St., Frederick, Md. 21701

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

HEPATIC FAILURE

Due to (or as a consequence of):

b.

METASTATIC LIVER CANCER

Due to (or as a consequence of):

c.

RENAL FAILURE DUE TO RHABDOMYOLYSIS

Due to (or as a consequence of):

d.

HYPERKALEMIA

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Richard A. Yeron, MD

29c. License number

D 41717

29d. Date signed (Month, Day, Year)

February 13, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Richard Yeron MD 27 West Seventh Street, Frederick, Maryland 21701

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

John A. Buckner-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06470

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Kimberly A. Pett

2. Date of Death

February 7, 1997

3. Time of Death

5:20 AM

4a. Facility Name (If not institution, give street and number)

25601 Kings Valley Road

4b. City, Town, or Location of Death

Damascus

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

212-68-8104

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

39

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 4, 1957

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Damascus

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

25601 Kings Valley Road

10f. Zip Code

20872

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own home

17. Father's Name (First, Middle, Last)

Leonard A. Peck

18. Mother's Name (First, Middle, Maiden Surname)

Mary Wolford

19a. Informant's Name/Relationship (Type, Print)

Larry J. Pett, Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

25601 Kings Valley Road, Damascus, Md. 20872

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. View Cemetery 2/10/97

Date

20c. Location - City or Town, State

Damascus, Md. 20872

21. Signature of Funeral Service Licensee

Olin L. Molesworth

22. Name and Address of Facility

Olin L. Molesworth, P.A., Funeral Home  
26401 Ridge Road, Damascus, Md. 20872

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. lung sarcoma (primary)

2 x 2 y

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. metastatic sarcoma to other lung

Due to (or as a consequence of):

c. &amp; bone

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Elhamy Eskander, M.D.

29c. License number

D 48184

29d. Date signed (Month, Day, Year)

February 7, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Elhamy Eskander, M.D.

501 W. 7th St., Frederick, Md.

31. Date filed (Month, Day, Year)

FEB 10 1997

32. Registrar's Signature

John B. Boudreau

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. The first part of the report is a general  
description of the project and its objectives.  
2. The second part is a detailed description of the  
methodology used in the study.  
3. The third part is a description of the results  
obtained from the study.  
4. The fourth part is a discussion of the results  
and their implications.  
5. The fifth part is a conclusion and a list of  
references.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06471

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hazel King Prayer

2. Date of Death  
Month Day Year  
January 22, 19973. Time of Death  
9:09 P.M.Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

061-34-7319

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan 13, 1933

9. Birthplace (State or Foreign Country)

Bahamas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Mt. Airy

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5313 Pommel Drive

10f. Zip Code

21771

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Lab Technician

16b. Kind of Business/Industry

Hospitals

17. Father's Name (First, Middle, Last)

Ernest King

18. Mother's Name (First, Middle, Maiden Surname)

Alice Roberts

19a. Informant's Name/Relationship (Type, Print)

Nathaniel H. Prayer, Sr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5313 Pommel Drive, Mt. Airy, MD 21771

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet Cemetery

Date

1/31/97

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

T. B. H. King

22. Name and Address of Facility

Stauffer Funeral Homes, P.A.

8 E. Ridgeville Blvd, Mt. Airy, Maryland 21771

23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis Syndrome

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 hours

b. Staphylococcal Bacteremia

Due to (or as a consequence of):

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Disseminated Zoster

Systemic lupus Erythematosus

Acute Gastrointestinal Hemorrhage

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mary P. Howell M.D.

29c. License number

D46075

29d. Date signed (Month, Day, Year)

1/22/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mary Howell 915 Toll House Avenue Frederick

31. Date filed (Month, Day, Year)

JAN 27 1997

32. Registrar's Signature

Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06472

## Certificate of Death

Reg. No.

|  |  |  |  |  |   |  |   |  |
|--|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>PHILIP WILFRED PHILBIN</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>FEB 13 1997</b>  |  | 3. Time of Death<br><b>12:40 AM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>NATIONAL NAVAL MEDICAL CENTER</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>   |  | 4c. County of Death<br><b>MONTGOMERY</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-50-0216</b>  |  | 6. Sex<br><b>1 M 2 F</b>   |  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 8, 1915</b>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Nebraska</b>  |  | 10a. State<br><b>none</b>  |  | 10b. County<br><b>none</b>  |  | 10c. City, Town or Location<br><b>Washington, D.C.</b>  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><b>1 Yes 2 No</b>   |  | 10e. Street and Number<br><b>5016 MacArthur Blvd., N.W.</b>  |  | 10f. Zip Code<br><b>20016</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|  | 11. Marital Status<br><b>1 Not Married 2 Married 3 Widowed 4 Divorced</b>  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><b>1 Yes 2 No</b>   |  | 14. Race - American Indian, Black, White, etc.<br><b>white</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>geophysist</b> |  | 16b. Kind of Business/Industry<br><b>U.S. Government</b>  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Morgan Philbin</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine Walsh</b>   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ada Marie Sherier Philbin/wife</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5016 MacArthur Blvd., N.W., Wash., D.C. 20016</b> |  |   |  |
|  | 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington National Cem. Feb. 24, 97</b>           |  | 20c. Location - City or Town, State<br><b>Arlington, Virginia</b>   |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>DeVol Funeral Home</b>  |  | 22. Name and Address of Facility<br><b>2222 Wisconsin Ave., N.W., Wash., D.C. 20007</b>   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>immediate Cause (Final disease or condition resulting in death)</b><br><b>a. SEPTIC SHOCK</b><br><b>Due to (or as a consequence of):</b> |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>                               |  | 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b>                            |  |
|  | 23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b>  |  | 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>  |  | 26. Place of Death (Check only one)<br><b>Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA</b>   |  | 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicidal 4 Homicidal 5 Pending investigation 6 Could not be determined</b> |  |
|  | 28a. Date of Injury (Month, Day, Year)<br><b>Feb 13 1997</b>   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><b>1 Yes 2 No</b>   |  | 28d. Describe how injury occurred<br><b>28e. Location (Street and Number or Rural Route Number, City or Town, State)</b>    |  |
| 29a. Certifier (Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  | 29b. Signature and title of certifier<br> |  | 29c. License number<br><b>01044600 (IN)</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>02/13/97</b> |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>T.H. BURGESS, LT, MC, USN</b>   |  | 31. Data filed (Month, Day, Year)<br><b>FEB 19 1997</b>  |  | 32. Registrar's Signature<br> |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06473

## Certificate of Death

Reg. No.

|  |  |  |   |   |  |   |  |  |  |  |
|--|--|--|---|---|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MARY PIRTZL</b>                               |  |   |   | 2. Date of Death<br>Month <b>FEB.</b> Day <b>13,</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>5:45 PM</b>   |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>25000 WOODFIELD RD.</b> |  |   |   | 4b. City, Town, or Location of Death<br><b>DAMASCUS</b>  |   | 4c. County of Death<br><b>MONTGOMERY</b>   |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>201-22-9057</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                              | 8. Date of Birth (Month, Day, Year)<br><b>MAY 15, 1909</b>                       |  |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>GERMANY</b>                                   |  |   |   |  |   |  |  |  |  |
| Usual Residence of Decedent  |  |  |   |   |  |   |  |  |  |  |
| 10a. State<br><b>MD.</b>   |  |  | 10b. County<br><b>MONTGOMERY</b>  |   | 10c. City, Town or Location<br><b>DAMASCUS</b>   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 10e. Street and Number<br><b>25000 WOODFIELD RD.</b>   |  |  |   |   | 10f. Zip Code<br><b>20872</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>          |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)  |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEWIFE</b> |  |   | 16b. Kind of Business/Industry<br><b>AT HOME</b>                                 |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>MICHAEL TIEFENBRUCKER</b>  |  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CLARA WARTNER</b>  |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>CLARE P. GINTHER/DAUGHTER</b>   |  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17917 MILL CREEK DR., DERWOOD, MD. 20855</b>   |   |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHAMBERS CREMATORY</b>   |   | Date<br><b>2/17</b>  |   | 20c. Location - City or Town, State<br><b>RIVERDALE, MD.</b>                     |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |  | 22. Name and Address of Facility<br><b>M00091 CHAMBERS FUNERAL HOMES, P.A. 20910</b>  |   | 22. Name and Address of Facility<br><b>SILVER SPRING, MD.</b>  |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. THROMBOTIC THROMBOCYTOPENIC PURPURA</b><br>Due to (or as a consequence of):<br><b>b. SEPSIS</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |   |   |  |   |  |  | Approximate Interval Between Onset and Death<br><b>1 DAY</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SENILE DEMENTIA</b>   |  |  |   |   |  |   |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |   |   |  |   |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |   |  |   |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |   |  |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  | 28d. Describe how injury occurred   |   |  |   |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |   |  |   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |   |   |  |   |  |  |  |  |
| 29b. Signature and title of certifier<br> <b>MD</b>   |  |  | 29c. License number<br><b>D 29730</b>   |   |  | 29d. Date signed (Month, Day, Year)<br><b>FEB. 14, 1997</b> |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>JAMES MICHAEL ANCHORS, M.D. 16220 FREDERICK RD., GAITHERSBURG, MD 20877</b>   |  |  |   |   |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 18 1997</b>  |  |  | 32. Registrar's Signature<br>  |   |  |   |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

Physician  
/Medical  
ExaminerState  
Registrar

1. The first part of the document is a letter from the Secretary of the Department of the Interior to the Secretary of the Department of the Army, dated 1900.

2. The second part of the document is a letter from the Secretary of the Department of the Interior to the Secretary of the Department of the Army, dated 1900.

3. The third part of the document is a letter from the Secretary of the Department of the Interior to the Secretary of the Department of the Army, dated 1900.

4. The fourth part of the document is a letter from the Secretary of the Department of the Interior to the Secretary of the Department of the Army, dated 1900.

5. The fifth part of the document is a letter from the Secretary of the Department of the Interior to the Secretary of the Department of the Army, dated 1900.



97 06474

## Reg. No.

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06475

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edward C. Powell

2. Date of Death

Month

Day

Year

Feb

17

1997

3. Time of Death

3:22 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Mariner Health Care Center

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

5. Social Security Number

220-12-8961

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

94

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept 14, 1902

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Montgomery

10c. City, Town or Location

Olney

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

16700 Batchelor Forest Rd,

10f. Zip Code

20832

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

3rd Grade

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Dock Worker

16b. Kind of Business/Industry

C.T. Kennedy Co.

17. Father's Name (First, Middle, Last)

Herbert Powell

18. Mother's Name (First, Middle, Maiden Surname)

Grace Myers

19a. Informant's Name/Relationship (Type, Print) (Son)

Mr Samuel C. Powell

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12115 Dalewood Dr, Wheaton, Md #20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bushy Park Cemetery

Date

2/22/97

20c. Location - City or Town, State

Cooksville, Md

21. Signature of Funeral Service Licensee

*George R. Snowden*

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.

ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Coronary artery disease*  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Arteriosclerosis cardiovascular*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of injury

(Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Myron L. Lenkin MD*

29c. License number

D066 H

29d. Date signed (Month, Day, Year)

2/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MYRON L. LENKIN MD

2309 SHOREFIELD RD  
WHEATON MD 20902

31. Date filed (Month, Day, Year)

FEB 20 1997

32. Registrar's Signature

*Julia Davidson-Randall*State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06476

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Raj Kumari Prasad

2. Date of Death

Month

Day

Year

FEB. 14<sup>th</sup>

1997

3. Time of Death

0100

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

217-76-5967

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

92

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 15, 1904

9. Birthplace (State or Foreign Country)

India

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Darnestown

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

15105 Water Oak Drive

10f. Zip Code

20878

10g. Citizen of What Country?

India

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian-Indian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Attorney

16b. Kind of Business/Industry

State

17. Father's Name (First, Middle, Last)

Raj Narain

18. Mother's Name (First, Middle, Maiden Surname)

Chemeli (not available)

19a. Informant's Name/Relationship (Type, Print)

Jai Raj N. Rajan/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15105 Water Oak Drive, Darnestown, Maryland 20878

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

Feb. 16, 1997

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Raj Kumar

M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/  
7557 Wisconsin Avenue  
Bethesda, Maryland 20814-3501

Bethesda-Chevy Chase, Inc.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

cardiac Arrest

b. Due to (or as a consequence of):

Respiratory failure

c. Due to (or as a consequence of):

Aspiration pneumonia

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

① Advanced Alzheimer's dementia

② Recurrent Aspiration pneumonia

③ Normal Pressure Hydrocephalus

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Sangeeta Simlote, M.D.

29c. License number

D 50276

29d. Date signed (Month, Day, Year)

February 15<sup>th</sup> 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sangeeta Simlote, M.D. 17904 Georgia Avenue, #304 Olney, Maryland 20832

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Julie Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06477

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Navanitrai Purohit

2. Date of Death

February 17 1997 11:50 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

5. Social Security Number

245-37-2574

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct. 10, 1921

9. Birthplace (State or Foreign Country)

India

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Montgomery10c. City, Town or Location  
Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

730 Oxford Square Drive

10f. Zip Code

20905

10g. Citizen of What Country?

India

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Indian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Chemical Company

17. Father's Name (First, Middle, Last)

Anopram M. Purohit

18. Mother's Name (First, Middle, Maiden Surname)

Ruxmani Dave

19a. Informant's Name/Relationship (Type, Print)

Suresh N. Purohit

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19900 Manor View Terrace, Laytonsville, MD 20882

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

chesapeake Crematory

Date

2-19-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Carol A. Delm

22. Name and Address of Facility

Rapp Funeral Services, P. A.

933 Gist Avenue, Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIO RESPIRATORY FAILURE

Due to (or as a consequence of):

b. SEPTIC SHOCK

Due to (or as a consequence of):

c. PANCYTOPENIA (APLASTIC ANEMIA) by 1 Day

Due to (or as a consequence of):

d. PNEUMONIA 3 days

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Julia Davidson-Randall MD

29c. License number

D42019

29d. Date signed (Month, Day, Year)

FEB 18 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIRAN CHANDHURY MD

7350 VANDUSEN LAUREL MD

20707

31. Date filed (Month, Day, Year)

FEB 21 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

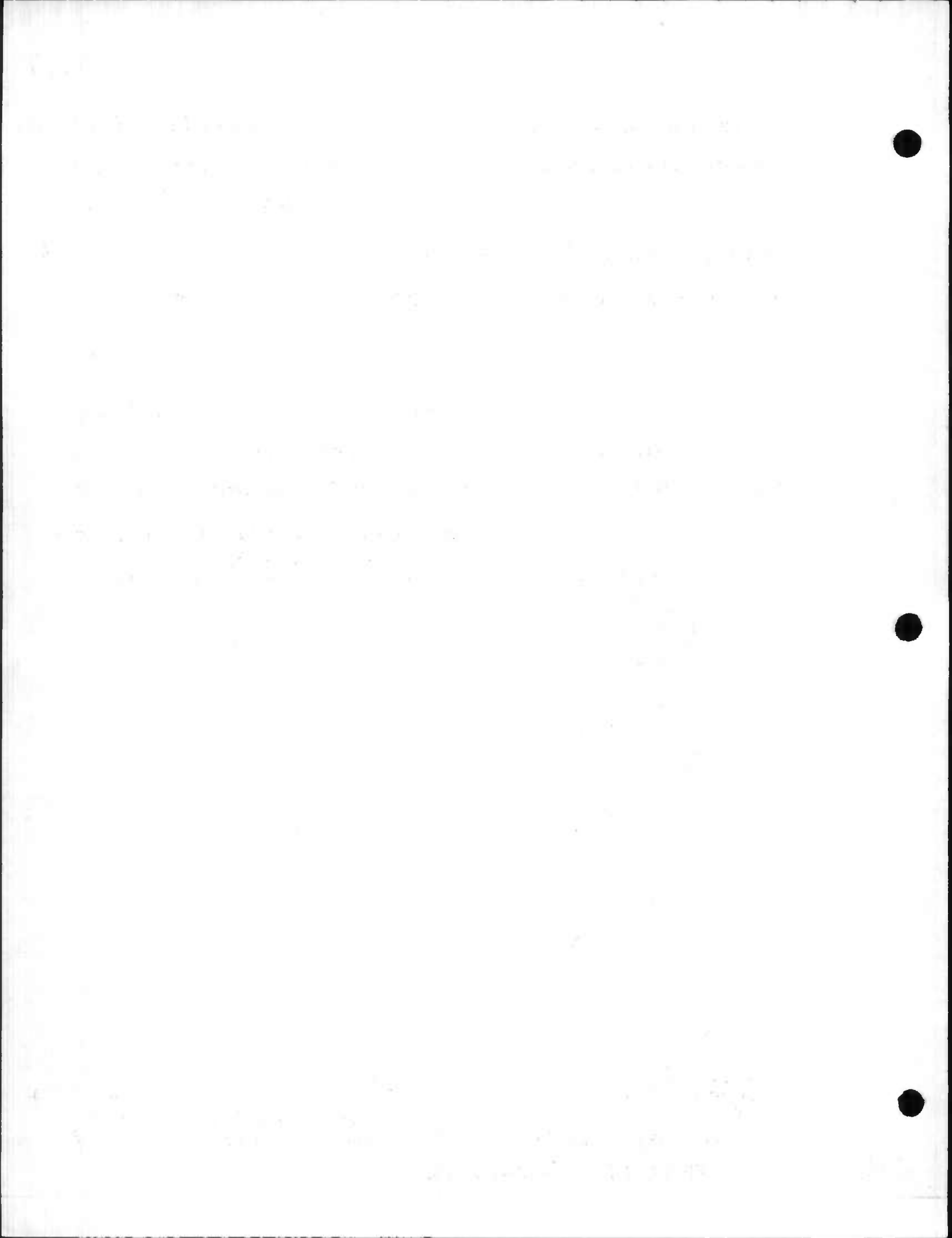
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06478

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD CURTIS POFF

2. Date of Death

Month Day Year  
February 21, 1997

3. Time of Death

2:04PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

VA Maryland Health Care System

4b. City, Town, or Location of Death

Perry Point

4c. County of Death

Cecil

5. Social Security Number

577-40-9845

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 30, 1932

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Chesapeake City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

960 Town Point Road

10f. Zip Code

21915

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give US Navy

Year or Dates: 1952-1955

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Carpentry

16b. Kind of Business/Industry

Residential  
remodelling

17. Father's Name (First, Middle, Last)

James Murry Poff

18. Mother's Name (First, Middle, Maiden Surname)

Alma Virginia Mills

19a. Informant's Name/Relationship (Type, Print)

Joanne C. Poff / Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

960 Town Point Road, Chesapeake City, MD 21915

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Maryland Veterans Cem.

Date

Feb. 25  
1997

20c. Location - City or Town, State

Hurlock, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Crouch Funeral Home

127 South Main Street, North East, MD 21901

23a. Path. Enter the disease, or condition, or other cause of death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Acute hepatic failure

Due to (or as a consequence of):

5 days

b. Liver cirrhosis

Due to (or as a consequence of):

3 months

Sequitally list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Questionable liver tumor with metastasis

Due to (or as a consequence of):

3 months

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D16608

29d. Date signed (Month, Day, Year)

February 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAM KEN LEUNG, M.D., VA Medical Center, Perry Point, Maryland 21902

31. Date filed (Month, Day, Year)

FEB 24 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
RegistrarBaltimore, Maryland 21215-0020  
Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06479

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY THERESA ROSZELL

2. Date of Death

Month Day Year  
FEBRUARY 17, 1997

3. Time of Death

1:30 PM

4a. Facility Name (If not institution, give street and number)

2125 MEMORIAL DRIVE

4b. City, Town, or Location of Death

OAKLAND

4c. County of Death

GARRETT

Funeral  
Director

5. Social Security Number

212-09-9682

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG 20, 1911

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

GARRETT

10c. City, Town or Location

OAKLAND

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2125 MEMORIAL DRIVE

10f. Zip Code

21550

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

WAITRESS

16b. Kind of Business/Industry

RESTAURANT

17. Father's Name (First, Middle, Last)

HUGH VICTOR O'DONNELL

18. Mother's Name (First, Middle, Maiden Surname)

DOROTHY THERESA GOTTLIEB

19a. Informant's Name/Relationship (Type, Print)

DORIS WAMPLER - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2125 MEMORIAL DRIVE OAKLAND, MD 21550

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

OMEGA CREMATORY

Date

2/20/97

20c. Location - City or Town, State

MORGANTOWN, WV

21. Signature of Funeral Service Licensee

M00167

22. Name and Address of Facility

P.O. BOX 243

DURST FUNERAL HOME - OAKLAND, MD 21550

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Acute renal failure

Due to (or as a consequence of):

2 wk.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Chronic renal failure

Due to (or as a consequence of):

7 yr.

c. ASCVD

Due to (or as a consequence of):

15 yr.

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of causa  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicida4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

042464

29d. Date signed (Month, Day, Year)

2/18/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. SAVOPOULOS, M.D.

1104 E. STATE STREET

TERRA ALTA, WV 26764

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

8



Amended Line 6 FCHD, JD

97 06480

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>LYDIA LOUISE RIDGEWAY</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 14, 1997</b>  |  | 3. TIME OF DEATH<br><b>8:05 a.m.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>231-62-3514</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>December 20, 1911</b>                         |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>Vindobona Nursing Home</b>   |  |  |  | 9. CITY, TOWN OR LOCATION OF DEATH<br><b>Braddock Heights</b>   |  | 10. COUNTY OF DEATH<br><b>Frederick</b>   |  |
| 11. STATE<br><b>Maryland</b>   |  | 12. COUNTY<br><b>Frederick</b>   |  | 13. CITY, TOWN OR LOCATION<br><b>Braddock Heights</b>   |  | 14. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 15. STREET AND NUMBER<br><b>6012 Jefferson Boulevard</b>   |  |  |  | 16. ZIP CODE<br><b>21714</b>  |  | 17. CITIZEN OF WHAT COUNTRY?<br><b>U. S. of A.</b>                                      |  |
| 18. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 19. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 20. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 21. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Caucasian</b>          |  |
| 22. DECEASED'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>7</b>  |  | 23. DECEASED'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 24. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>  |  |   |  |
| 25. FATHER'S NAME (First, Middle, Last)<br><b>Russell Samuel Gordon</b>  |  |  |  | 26. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Carrie L. McGaha</b>  |  |   |  |
| 27. INFORMANT'S NAME (Type/Print)<br><b>David Lee Ridgeway</b>   |  |  |  | 28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7019 Ridge Road, Frederick, Maryland 21702</b>   |  |   |  |
| 29. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Lovettsville Union 2/17/97</b>  |  | 31. DATE<br><b>2/17/97</b>  |  | 32. LOCATION — City or Town, State<br><b>Lovettsville Va.</b>                           |  |
| 33. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>W. J. M. Jura</i>  |  |  |  | 34. NAME AND ADDRESS OF FACILITY<br><b>Loudoun Funeral Chapel<br/>158 Catoclin Circle, S.E., Leesburg, VA</b>   |  |   |  |
| 35. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Congestive heart failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Ischemic Cardiovascular disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____<br>Approximately Interval Between Onset and Death<br><b>days</b><br><b>years</b> |  |  |  |   |  |   |  |
| 36. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alzheimer's dementia</b>  |  |  |  |   |  |   |  |
| 37. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  | 38. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 39. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |
| 40. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 41. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 42. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 43. DATE OF INJURY (Month, Day, Year)  |  | 44. TIME OF INJURY<br><b>M</b>  |  | 45. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO     |  |
| 46. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 47. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |
| 48. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 49. SIGNATURE AND TITLE OF CERTIFIER<br><b>Kathleen Stern MD</b>   |  |  |  | 50. LICENSE NUMBER<br><b>D32073</b>   |  | 51. DATE SIGNED (Month, Day, Year)<br><b>February 14, 1997</b>                          |  |
| 52. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Kathleen Stern, M.D. 610 9th Avenue, Brunswick, Maryland 21716</b>   |  |  |  |   |  |   |  |
| 53. DATE FILED (Month, Day, Year)<br><b>FEB 20 1997</b>  |  |  |  | 54. REGISTRAR'S SIGNATURE<br><i>John Davidson Ricketts</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



97 06481

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Sister Dorothy Reith   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb. 8, 1997   |  | 3. TIME OF DEATH<br>2:40 A. M.   |  |
| 4. SOCIAL SECURITY NUMBER<br>379-52-9535   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>88 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Oct. 5, 1908  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Washington, DC   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Villa St. Michael  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Emmitsburg,   |  |
| 9c. COUNTY OF DEATH<br>Frederick   |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Frederick   |  |
| 10c. CITY, TOWN OR LOCATION<br>Emmitsburg  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>333 South Seton Avenue   |  |
| 10f. ZIP CODE<br>21727   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>Secondary  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Group Mother, Sacristan  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Religious Community Daughters of Charity   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>William A. Reith, Sr.   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Georgianna E. Gibbons   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Sister Camilla Harant  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>333 S. Seton Avenue, Emmitsburg, MD 21727   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>ST. JOSEPH'S 2/11/97  |  | 20c. LOCATION — City or Town, State<br>EMMITSBURG, MD.   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>John M. Skiles  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>SKILES FUNERAL HOME<br>210 W. MAIN ST., EMMITSBURG, MD. 21727  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebral Infarction<br>DUE TO (OR AS A CONSEQUENCE OF): Atherosclerotic Vascular Disease 10 yrs<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Hypertension |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Alan Carroll MD   |  |  |  | 29c. LICENSE NUMBER<br>D18705  |  | 29d. DATE SIGNED (Month, Day, Year)<br>FEBRUARY 8, 1997  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>ALAN CARROLL, M.D., 310 S. SETON AVE., EMMITSBURG, MD. 21727  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>FEB 10 1997   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John A. Carroll   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06482

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SARA F. REAVIN

2. Date of Death

Month  
FEB.Day  
18,Year  
1997

3. Time of Death

7:11 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

087-03-8348

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
SEPT. 22, 1912

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

5901 MONTROSE RD. #C1106

10f. Zip Code

20852

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

WRITER

16b. Kind of Business/Industry

NOVELS, PLAYS, &amp; POETRY

17. Father's Name (First, Middle, Last)

ELIAS KATZ

18. Mother's Name (First, Middle, Maiden Surname)

ANNA TOBAK

19a. Informant's Name/Relationship (Type, Print)

SUSAN LENDER/DAUGHTER-IN-LAW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4315 IVY GLEN RD., WHEATON, MD. 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KERHONKSON JEWISH CEMETERY 2/23

Date

20c. Location - City or Town, State

KERHONKSON, N.Y.

21. Signature of Funeral Service Licensee

W. A. Chambers

22. Name and Address of Facility

MO0091 CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 HRS.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. N. Rosenbaum

29c. License number

DO9834

29d. Date signed (Month, Day, Year)

2/18/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BARRY N. ROSENBAUM M.D.  
3720 FARRAGUT AVE. KENSINGTON, MD 20895

31. Date filed (Month, Day, Year)

FEB 21 1997

32. Registrar's Signature

J. Davidson-Rodell

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06483

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BENJAMIN

RATNER

2. Date of Death  
Month Day Year

FEBRUARY 17, 1997

3. Time of Death

12:57 AM

4a. Facility Name (If not institution, give street and number)

HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

578-42-1940

6. Sex

M F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

02/02/1908

9. Birthplace (State or Foreign Country)

UKRAINE

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

6105 MONTROSE ROAD

10f. Zip Code

20852

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

METEOROLOGIST

16b. Kind of Business/Industry

WEATHER BUREAU

17. Father's Name (First, Middle, Last)

JOSEPH

RATNER

18. Mother's Name (First, Middle, Maiden Surname)

BESSIE

'UNAVAILABLE'

19a. Informant's Name/Relationship (Type, Print)

PHYLLIS SMOLKIN (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2714 BLAINE DRIVE CHEVY CHASE, MARYLAND 20815

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

D.C. LODGE ELESAVETGRAD 2/19/97

Date

20c. Location - City or Town, State

WASHINGTON, D.C.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC.

1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. DEMENTIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. UNKNOWN CAUSE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)X ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 18084

29d. Date signed (Month, Day, Year)

FEBRUARY 17, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

D.D. PATEL, M.D. 6121 MONTROSE ROAD ROCKVILLE, MARYLAND 20852

31. Date filed (Month, Day, Year)

FEB 19 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1937 6 1 0

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06484

## Certificate of Death

Reg. No.

|   |  |  |   |   |  |  |  |  |
|---|--|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>DEBRA ROZANSKY</b>  |  |   |   | 2. Date of Death<br>Month <b>FEB</b> Day <b>14</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>3:00 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>BAYVIEW MEDICAL CENTER</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>Baltimore City</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-60-2559</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>40</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 18, 1957</b>  | 9. Birthplace (State or Foreign Country)<br><b>Wash. DC</b>  |
|   | Usual Residence of Decedent  |  |   |   |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Md.</b>   | 10b. County<br><b>Montgomery</b>       | 10c. City, Town or Location<br><b>Bethesda</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
|   | 10e. Street and Number<br><b>7401 Westlake Terrace #209</b>  |  |   |   | 10f. Zip Code<br><b>20817</b>  |  | 10g. Citizen of What Country?<br><b>US</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>   |  | College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Wilbert Rozansky</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Florence Rozansky</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Florence Rozansky</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6109 Highboro Dr. Bethesda, Md. 20817</b>  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King David Memorial Gardens 2/16</b>                                 |   | Date   |  | 20c. Location - City or Town, State<br><b>Falls Church, Va.</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br><b>Edward Sagel Funeral Direction<br/>1091 Rockville Pike Rockville, Md. 20852</b>   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Adult Respiratory Distress Syndrome</b><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |   |  |  |  | Approximate Interval Between Onset and Death<br><b>WEEKS</b>   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year) |   | 28b. Time of injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>97111</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>14 Feb 97</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>4940 EASTERN AVE BALTIMORE MD 21224</b>  |  |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 18 1997</b>   |  |  |   | 32. Registrar's Signature<br>  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

97 06485

Reg. No.

|   |  |   |  |  |  |  |   |  |   |  |  |                                    |  |   |  |
|---|--|---|--|--|--|--|---|--|---|--|--|------------------------------------|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>STEPHANIE ANN RYDZEWSKI</b>             |   |  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>FEB. 15, 1997</b>              |  | 3. Time of Death<br><b>1115 A</b>                           |  |  |                                    |  |   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>58 BRALEN CT.</b> |   |  |  |  |  | 4b. City, Town, or Location of Death<br><b>Gaithersburg</b>             |  | 4c. County of Death<br><b>MONTGOMERY</b>                    |  |  |                                    |  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-02-4899</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>21</b> Yrs. |  | 8. Date of Birth (Month, Day, Year)<br><b>May 12, 1975</b>              |  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b> |  |  |                                    |  |   |  |
|   | Usual Residence of Decedent  |   |  |  |  |  |   |  |   |  |  |                                    |  |   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Gaithersburg</b>   |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |                                    |  |   |  |
| 10e. Street and Number<br><b>19500 Ridge Heights Drive</b>  |  |   |  | 10f. Zip Code<br><b>20879</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |   |  |   |  |  |                                    |  |   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |  |  |                                    |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bartender/Waitress</b>   |  |  | 16b. Kind of Business/Industry<br><b>Restaurant</b>                     |  |   |  |  |                                    |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Anthony Joseph Rydzewski</b>  |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Joanne Ferullo</b>   |   |  |   |  |  |                                    |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Anthony J. Rydzewski/Father</b>  |  |   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>19500 Ridge Heights Dr., Gaithersburg, MD. 20879</b> |   |  |   |  |  |                                    |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Rose of Lima Cemetery</b>  |  | 20c. Date<br><b>2/19/97</b>  |  | 20d. Location - City or Town, State<br><b>Gaithersburg, MD.</b>  |   |  |   |  |  |                                    |  |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Michael D. Gilbey</i>   |  |   |  | 22. Name and Address of Facility<br><b>DeVol Funeral Home</b><br><b>10 East Deer Park Dr., Gaithersburg, MD. 20877</b>   |  |  |   |  |   |  |  |                                    |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Gunshot wound to head</i><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |  |                                    |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |                                    |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                    |  |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |  |  |   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOUSE</b> |  |                                    |  |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury<br>Found (Month, Day, Year)<br><b>2-15-97</b>   |  | 28b. Time of Injury<br>Found <b>0900</b> M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred<br><i>Subject shot self</i>                                  |   |  |  |                                    |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>IN HOUSE</b>   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>#58 BraLEN &amp; Gaithersburg, Montgomery Co., MD</b>  |  |  |   |  |   |  |  |                                    |  |   |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  |   |  |   | 29b. Signature and title of certifier<br><i>Donald G. Wright MD</i>  |  | 29c. License number<br><b>OCME</b> |  | 29d. Date signed (Month, Day, Year)<br><b>FEB. 16, 1997</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |  |  |  |  |   |  |   |  |  |                                    |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 19 1997</b>   |  |   |  | 32. Registrar's Signature<br><i>John Davidson-Randall</i>  |  |  |   |  |   |  |  |                                    |  |   |  |

Baltimore, Maryland 21215-0020  
To Be Completed by Funeral DirectorPhysician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06486

## Certificate of Death

Reg. No.

|  |  |   |  |  |   |   |   |   |                               |   |                                  |                        |                                  |  |    |       |    |
|--|--|---|--|--|---|---|---|---|-------------------------------|---|----------------------------------|------------------------|----------------------------------|--|----|-------|----|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>GLOKIA J. RUSSEN</b>                        |   |  |  | 2. Date of Death<br>Month <b>FEB</b> , Day <b>13</b> , Year <b>97</b> |   | 3. Time of Death<br><b>1110</b>                             |   |                               |   |                                  |                        |                                  |  |    |       |    |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Suburban Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>               |   | 4c. County of Death<br><b>MONTGOMERY</b>                    |   |                               |   |                                  |                        |                                  |  |    |       |    |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-48-8880</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>49</b> Yrs.                      |   | 8. Date of Birth (Month, Day, Year)<br><b>Mar. 23, 1947</b> |   |                               |   |                                  |                        |                                  |  |    |       |    |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Montgomery</b>                                      |   | 10c. City, Town or Location<br><b>Potomac</b>               |   |                               |   |                                  |                        |                                  |  |    |       |    |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>7834 Scotland Drive</b>  |  | 10f. Zip Code<br><b>20854</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |   |                               |   |                                  |                        |                                  |  |    |       |    |
| 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                     |   |   |                               |   |                                  |                        |                                  |  |    |       |    |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Home-maker</b>  |  | 16b. Kind of Business/Industry<br><b>None</b>  |   |   |   |   |                               |   |                                  |                        |                                  |  |    |       |    |
| 17. Father's Name (First, Middle, Last)<br><b>Clyde Smith</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gladys E. Smith</b>  |   |   |   |   |                               |   |                                  |                        |                                  |  |    |       |    |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Gail D. Curtis (Daughter)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7834 Scotland Dr., Potomac, MD 20854</b>   |   |   |   |   |                               |   |                                  |                        |                                  |  |    |       |    |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Good Hope Church Cem.</b>  |  | 20c. Location - City or Town, State<br><b>2/17 Silver Spring, MD</b>   |   |   |   |   |                               |   |                                  |                        |                                  |  |    |       |    |
| 21. Signature of Funeral Service Licensee<br><i>George R. Brunk</i>  |  |   |  | 22. Name and Address of Facility<br><b>SNOWDEN FUNERAL HOME, P.A.<br/>ROCKVILLE, MD 20850</b>  |   |   |   |   |                               |   |                                  |                        |                                  |  |    |       |    |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |   |   |   |   |                               |   |                                  |                        |                                  |  |    |       |    |
| <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Cerebral hemorrhage</b></td> <td rowspan="4">Approximate Interval Between Onset and Death<br/><b>2 days</b></td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b. <b>Hypertension</b></td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td rowspan="2">Years</td> </tr> <tr> <td>d.</td> </tr> </table> |  |   |  |  |   |   |   | Immediate Cause (Final disease or condition resulting in death) | a. <b>Cerebral hemorrhage</b> | Approximate Interval Between Onset and Death<br><b>2 days</b> | Due to (or as a consequence of): | b. <b>Hypertension</b> | Due to (or as a consequence of): | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. | Years | d. |
| Immediate Cause (Final disease or condition resulting in death)  | a. <b>Cerebral hemorrhage</b>  | Approximate Interval Between Onset and Death<br><b>2 days</b>   |  |  |   |   |   |   |                               |   |                                  |                        |                                  |  |    |       |    |
|  | Due to (or as a consequence of):   |   |  |  |   |   |   |   |                               |   |                                  |                        |                                  |  |    |       |    |
|  | b. <b>Hypertension</b>   |   |  |  |   |   |   |   |                               |   |                                  |                        |                                  |  |    |       |    |
|  | Due to (or as a consequence of):   |   |  |  |   |   |   |   |                               |   |                                  |                        |                                  |  |    |       |    |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | c.   | Years   |  |  |   |   |   |   |                               |   |                                  |                        |                                  |  |    |       |    |
|  | d.   |   |  |  |   |   |   |   |                               |   |                                  |                        |                                  |  |    |       |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |   |   |   |   |                               |   |                                  |                        |                                  |  |    |       |    |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |   |   |   |   |                               |   |                                  |                        |                                  |  |    |       |    |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |   |   |   |   |                               |   |                                  |                        |                                  |  |    |       |    |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |   |   |   |   |                               |   |                                  |                        |                                  |  |    |       |    |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |   |   |                               |   |                                  |                        |                                  |  |    |       |    |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   |                               |   |                                  |                        |                                  |  |    |       |    |
|  |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |   |   |                               |   |                                  |                        |                                  |  |    |       |    |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |   |   |   |   |                               |   |                                  |                        |                                  |  |    |       |    |
| 29b. Signature and title of certifier<br><i>Spencer Beck, MD</i>   |  |   |  | 29c. License number<br><b>D 46052</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>2/13/97</b>                                       |   |   |                               |   |                                  |                        |                                  |  |    |       |    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SPENCER BECK, MD 1600 Crain Hwy, SW, Glen Burnie, MD 21061</b>  |  |   |  |  |   |   |   |   |                               |   |                                  |                        |                                  |  |    |       |    |
| 31. Date filed (Month, Day, Year)<br><b>FEB 18 1997</b>  |  |   |  | 32. Registrar's Signature<br><i>Julia Davidson-Rodell</i>  |   |   |   |   |                               |   |                                  |                        |                                  |  |    |       |    |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



97 06487

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Verna Mae Roark</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 19, 1997</b>   |  | 3. TIME OF DEATH<br><b>6:35 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-14-1756</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan 12 1913</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Tennessee</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Caroline Nursing Home, Inc.</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Denton</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Caroline</b>   |  |  |  | 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Talbot</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>St. Michaels</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>24354 Widgeon Place Unit 20</b>   |  |
| 10f. ZIP CODE<br><b>21663</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>12</b><br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Domestic Worker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Private Homes</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Roby Jones</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Hartsoe</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Roger R Roark, Sr. / Son</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>24354 Widgeon Place Unit 20 St Michaels MD 21663</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>West Nottingham Cemetery Feb 24 1997 Colora MD</b>   |  | 20c. LOCATION — City or Town, State  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>R. T. Foard Funeral Home, P.A.<br/>111 SQueen St. Rising Sun MD 21911</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |  |  |  |  |
| a. <b>Sepsis</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| b. <b>Urinary Tract Infection</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| c. <b>Dementia</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| d. <b>Pneumonia</b>  |  |  |  |  |  |  |  |
| Approximate Interval Between Onset and Death<br><b>6 hours</b>   |  |  |  |  |  |  |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE NOW INJURY OCCURED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><b>D0051132</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Feb. 20, 1997</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Jorge Abrego, M.D., PO Box 660, Denton, Maryland 21629</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>FEB 21 1997</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06488

## Certificate of Death

Reg. No.

|   |   |  |   |   |  |  |  |  |  |  |  |
|---|---|--|---|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Hilda McCool Rudolph  |  |   |   | 2. Date of Death<br>Month Day Year<br>Feb. 22, 1997  |  | 3. Time of Death<br>11:10A.M.  |  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Medpointe   |  |   |   | 4b. City, Town, or Location of Death<br>Elkton Md.   |  | 4c. County of Death<br>Cecil   |  |  |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>215-74-0688  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>95 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.               | 8. Date of Birth (Month, Day, Year)<br>December 20, 1901   |  | 9. Birthplace (State or Foreign Country)<br>Maryland |  |  |
|   | Usual Residence of Decedent   |  |   |   |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br>Maryland  |  | 10b. County<br>Cecil  |   | 10c. City, Town or Location<br>Elkton  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
|   | 10e. Street and Number<br>518 North Street  |  |   |   | 10f. Zip Code<br>21921   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11<br>College (1-4or 5+) 2   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Housewife  |   |  | 16b. Kind of Business/Industry<br>House Hold |  |  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>John W. McCool   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Etta J. Jones   |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Edward R. Lupinek Grand-Son   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>302 S. Cass St. Middletown, Del. 19709  |  |  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Elkton Cemetery   |   | Date<br>Feb. 24, 97  |  | 20c. Location - City or Town, State<br>Elkton Md.  |  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |   | 22. Name and Address of Facility<br>Gee Funeral Home 259 E. Main St. Elkton. Md.   |  |  |  |  |  |  |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Hypertension<br>Due to (or as a consequence of):<br>b. Anterior wall Myocardial Infarction<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br>30 yrs<br>20 yrs |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Her. Insulin Dependent Diabetes Mellitus<br>Aneurysm  |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  |  |  |  |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                    |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br>   |   | 29c. License number<br>D 33570   |  | 29d. Date signed (Month, Day, Year)<br>February 22 1997  |  |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Timothy O'Donnell, M.D.<br>6635 W. DE 19400   |  |   |   |  |  |  |  |  |  |  |
| State<br>Registrar                            | 31. Date filed (Month, Day, Year)<br>FEB 25 1997  |  |   |   | 32. Registrar's Signature<br>  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at 6055.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06489

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |   |  |
|---|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MARY ANNA RILL</b>   |  |   |  | 2. Date of Death<br>Month <b>FEB</b> Day <b>22</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>2:15 AM</b>                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>2749 LEPPON LANE</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>FINKSBURG</b>   |  | 4c. County of Death<br><b>CARROLL</b>                                   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-30-9231</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>MARCH 4, 1915</b>             |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  | 10a. State<br><b>MD.</b>  |  | 10b. County<br><b>CARROLL</b>  |  | 10c. City, Town or Location<br><b>FINKSBURG</b>                         |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>2749 LEPPON LANE</b>   |  | 10f. Zip Code<br><b>21102</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEWIFE</b>                     |  | 16b. Kind of Business/Industry<br><b>DOMESTIC</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>GEORGE MANN</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNIE LEPPON</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>GEORGE THOMAS RILL</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3538 LINEBORO RD. MANCHESTER MD. 21102</b>   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)           |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CARROLLTON CEMETERY</b>  |  | 20c. Location - City or Town, State<br><b>FINKSBURG, MD.</b>   |  | 20d. Date<br><b>FEB 24</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Robert A. Myers</b>   |  |   |  | 22. Name and Address of Facility<br><b>MYERS FUNERAL HOME WESTMINSTER, MD. 21157</b>   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Acute myocardial infarction</b> |  |   |  |  |  |   |  |
|   | 23b. Approximate Interval Between Onset and Death<br><b>30 yrs</b>  |  |   |  |  |  |   |  |
|   | 23c. Due to (or as a consequence of):<br><b>ASCVD</b>   |  |   |  |  |  |   |  |
| 23d. Due to (or as a consequence of):<br><b>Vascular hypertension</b>   |   |  |   |  |  |  |   |  |
| 23e. Due to (or as a consequence of):   |   |  |   |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Degenerative Arteriosclerosis</b>  |   |  |   |  |  |  |   |  |
| 23f. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |   |  |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |  |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |   |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   |  |   |  |  |  |   |  |
| 28a. Date of Injury (Month, Day, Year)  |   |  |   |  |  |  |   |  |
| 28b. Time of Injury<br><b>M</b>   |   |  |   |  |  |  |   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |  |  |   |  |
| 28d. Describe how injury occurred   |   |  |   |  |  |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   |  |  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |  |  |   |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>   |   |  |   |  |  |  |   |  |
| 29c. License number<br><b>010727E</b>   |   |  |   |  |  |  |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>Feb. 24, 1997</b>   |   |  |   |  |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David E. Zickafoose, MD 220 Potomac Ave. Hanover, PA 17331</b>   |   |  |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 1997</b>   |   |  |   |  |  |  |   |  |
| 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06490

## Certificate of Death

Reg. No.

|   |   |  |  |  |   |  |   |  |   |  |
|---|---|--|--|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>MABEL MARIE RIFFLE</b>   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>FEB. 16, 1997</b>  |  |   |  | 3. Time of Death<br><b>7:30 PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>330 Gorsuch Rd.</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>WESTMINSTER</b>  |  |   |  | 4c. County of Death<br><b>CARROLL</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>216-14-6994</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.  |  | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.  |  |
|   | 8. Date of Birth (Month, Day, Year)<br><b>3/23/1912</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                |  | Usual Residence of Decedent   |  | 10a. State<br><b>MD.</b>  |  | 10b. County<br><b>CARROLL</b>   |  |
| To Be Completed by Funeral Director           | 10c. City, Town or Location<br><b>WESTMINSTER</b>   |  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>330 GORSUCH RD.</b>  |  | 10f. Zip Code<br><b>21157</b>   |  |
|   | 10g. Citizen of What Country?<br><b>USA.</b>  |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEWIFE</b>   |  | 16b. Kind of Business/Industry<br><b>HOME MAKING</b>  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>HARRY GRAHAM</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARTHA WISE</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>CARROLL N. RIFFLE -HUSBAND</b>   |  |   |  |
|   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>330 GORSUCH RD., WESTMINSTER, MD. 21157</b>   |  |  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>TRINITY LUTHERAN CEM.</b>  |  | 20c. Date<br><b>2/19/97</b>   |  |
|   | 20d. Location - City or Town, State<br><b>TANEYTOWN, MD.</b>  |  |  |  | 21. Signature of Funeral Director Licensee<br>  |  | 22. Name and Address of Facility<br><b>FLETCHER FUNERAL HOME<br/>254 E. MAIN ST., WESTMINSTER, MD. 21157</b>  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>EMPHYSEMA</b>   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   | 23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ISCHEMIC CARDIOPATHY</b>  |  |  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospit: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  |  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|   | 28d. Describe how injury occurred   |  |  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D29246</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/17/97</b>   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  |  |  |  | 31. Date filed (Month, Day, Year)<br><b>FEB 19 1997</b>   |  | 32. Registrar's Signature<br>   |  |   |  |
|   | State Registrar   |  |  |  |   |  |   |  |   |  |

Baltimore, Maryland 21215-0020

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

97 06491

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROZALIA (N.M.N.) SZCZECZ

2. Date of Death  
Month Day Year

2 15 97

3. Time of Death

11:30 A.M.

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL CONVALESCENT CENTER

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

216-07-4705

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

12-17-1901

9. Birthplace (State or Foreign Country)

POLAND

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

LINTHICUM

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

101 JUNIPER CIRCLE

10f. Zip Code

21090

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SEAMSTRESS

16b. Kind of Business/Industry

CLOTHING

17. Father's Name (First, Middle, Last)

JOHN

MALINOWSKI

18. Mother's Name (First, Middle, Maiden Surname)

BALBINA

KARWONSKA

19a. Informant's Name/Relationship (Type, Print)

LOUIS E. SZECH

SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

101 JUNIPER CIRCLE LINTHICUM, MD. 21090

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HOLY ROSARY CEMETERY

Date

2-18-97

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME

1 SECOND AVE. S.W. GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

30 min - 1 hour

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D40491

29d. Date signed (Month, Day, Year)

FEB. 17. 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sgt. M. A. Riser 800 North Hammock Ferry Road Linticum 21090

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06492

Reg. No.

|   |   |  |   |   |  |                          |   |   |  |  |  |
|---|---|--|---|---|--|--------------------------|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>HESTER M. SESKER  |  |   |   | 2. Date of Death<br>Month Day Year<br>FEB. 18 1997   |                          |   |   | 3. Time of Death<br>0722                             |  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br>ANNE ARUNDEL MEDICAL CENTER   |  |   |   | 4b. City, Town, or Location of Death<br>ANNAPOLIS  |                          |   |   | 4c. County of Death<br>ANNE ARUNDEL                  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>213-36-0119  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (in yrs. last birthday)<br>58 Yrs.  |                          | 8. Date of Birth (Month, Day, Year)<br>FEB. 9 1939                |   | 9. Birthplace (State or Foreign Country)<br>MARYLAND |  |  |
|   | Usual Residence of Decedent   |  |   |   | 10e. State<br>MARYLAND   |                          |   |   | 10b. County<br>ANNE ARUNDEL                          |  |  |
| To Be Completed by Funeral Director   | 10c. City, Town or Location<br>LOTHIAN  |  |   |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |                          |   |   |  |  |  |
|   | 10e. Street and Number<br>5058 SANDS ROAD   |  |   |   | 10f. Zip Code<br>20711   |                          |   |   | 10g. Citizen of What Country?<br>US                  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                          | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK  |   |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>11th  |  | College (1-4or 5+)<br>0   |   | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>CUSTODIAN   |                          | 16b. Kind of Business/Industry<br>PRINCE GEORGE COMMUNITY COLLEGE |   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>ARTHUR DAVIS   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>HENRITTEA HARRISON  |                          |   |   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>CHARLES SESKER (HUSBAND)  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5058 SANDS ROAD LOTHIAN, MD. 20711  |                          |   |   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>ANNAPOLIS MEM. GARDENS  |   | Date<br>2/22/97  |                          | 20c. Location - City or Town, State<br>ANNAPOLIS, MD.             |   |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>Larry H. Reese   |  |   |   | 22. Name and Address of Facility<br>WM. REESE & SONS MORTUARY, P.A.<br>821 WEST STREET ANNAPOLIS, MD. 21401  |                          |   |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. METASTATIC LUNG CANCER<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br>18 MONTHS |  |   |   |  |                          |   |   |  |  |  |
|   | 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>COPD<br>PERFORATED VISCUS  |  |   |   |  |                          |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   | 28. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |                          |   |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   |  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred              |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   | 29b. Signature and Title of Certifier<br>Peter R. Borge MD  |  |                          |   | 29c. License number<br>D16364   |  | 29d. Date signed (Month, Day, Year)<br>2/18/97 |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>600 Bestgate Rd. Anna, Md. 21401  |   |  |   |   |  |                          |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 20 1997  |   |  |   | 32. Registrar's Signature<br>[Signature]  |  |                          |   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 06493

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EILEEN LUCILLE STEYER

2. Date of Death

Month Day Year  
FEBRUARY 14, 1997

3. Time of Death

12:10 AM

4a. Facility Name (If not institution, give street and number)

8 WALLMAN ROAD

4b. City, Town, or Location of Death

OAKLAND

4c. County of Death

GARRETT

Funeral  
Director

5. Social Security Number

218-16-3848

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
DEC 14, 1923

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

GARRETT

10c. City, Town or Location

OAKLAND

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

8 WALLMAN ROAD

10f. Zip Code

21550

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

FLORIST

16b. Kind of Business/Industry

GREENHOUSE

17. Father's Name (First, Middle, Last)

HERBERT PAUL HARVEY

18. Mother's Name (First, Middle, Maiden Surname)

EVA LENA THOMPSON

19a. Informant's Name/Relationship (Type, Print)

PAUL E. STEYER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 WALLMAN ROAD OAKLAND, MARYLAND 21550

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

WHITE CHARCH CEMETERY

Date

2/17/97

20c. Location - City or Town, State

OAKLAND, MARYLAND

21. Signature of Funeral Service Licensee

MO0167

22. Name and Address of Facility

P.O. BOX 243  
DURST FUNERAL HOME - OAKLAND, MD 21550

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. lymphoma

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

9 months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

congestive heart failure

high blood pressure

chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

28. Place of Death (Check only one)

Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D15333

29d. Date signed (Month, Day, Year)

FEBRUARY 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas G. Johnson, M.D. 311 N. Fourth St Oakland, MD 21550

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

State

Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the Burial-Transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06494

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES SMITH SHAFFER

2. Date of Death

Month Day Year  
FEBRUARY 19, 1997

3. Time of Death

12:30 A.M.

4a. Facility Name (If not institution, give street and number)

365 DENNETT ROAD

4b. City, Town, or Location of Death

OAKLAND

4c. County of Death

GARRETT

Funeral  
Director

5. Social Security Number

234-10-5291

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JUNE 11, 1914

9. Birthplace (State or Foreign Country)

WEST VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

GARRETT

10c. City, Town or Location

OAKLAND

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

365 DENNETT ROAD

10f. Zip Code

21550

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SALESMAN

16b. Kind of Business/Industry

AUTO PARTS

17. Father's Name (First, Middle, Last)

DAVID C. SHAFFER

18. Mother's Name (First, Middle, Maiden Surname)

ELLA MAE SMITH

19a. Informant's Name/Relationship (Type, Print)

BETTY SHAFFER - WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

365 DENNETT ROAD OAKLAND, MD 21550

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRETT MEMORIAL GARDENS

Date

2/22

20c. Location - City or Town, State

OAKLAND, MARYLAND

21. Signature of Funeral Service Licensee

 MO0167

22. Name and Address of Facility

P.O. BOX 243  
DURST FUNERAL HOME - OAKLAND, MD 21550

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Squamous Cell Cancer of Lung

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 years

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metastatic prostate cancer, Coronary Artery Disease

Hypertension

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

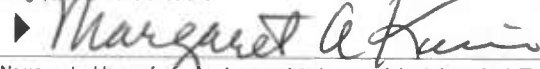
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D26650

29d. Date signed (Month, Day, Year)

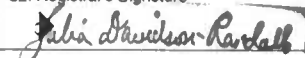
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Margaret A. Kaiser, M.D. PO Box 486 Oakland, MD 21550

31. Date filed (Month, Day, Year)

FEB 21 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06495

## Certificate of Death

Reg. No.

|   |   |  |  |   |  |                          |   |  |
|---|---|--|--|---|--|--------------------------|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Emma Blanche Swain  |  |  |   | 2. Date of Death<br>Month Day Year<br>February 16, 1997  |                          | 3. Time of Death<br>11:09 a.m.  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Frederick Memorial Hospital   |  |  |   | 4b. City, Town, or Location of Death<br>Frederick  |                          | 4c. County of Death<br>Frederick  |  |
| Funeral<br>Director   | 5. Social Security Number<br>217-09-7494  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>85 Yrs.  |                          | 8. Date of Birth (Month, Day, Year)<br>May 22, 1911   |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland  |  | 10a. State<br>Maryland   |   | 10b. County<br>Frederick   |                          | 10c. City, Town or Location<br>Frederick  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   | 10e. Street and Number<br>241 West Fifth Street  |                          | 10f. Zip Code<br>21701  |  |
|   | 10g. Citizen of What Country?<br>U.S.A.   |  |  |   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                   |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
|   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |                          | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7 College (1-4 or 5+)                                  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |  |  |   | 16b. Kind of Business/Industry<br>Own Home   |                          |   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Roy KEFAUVER   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Katie YOUNKINS  |                          |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Mary Catherine Main, Daughter  |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>506 Military Road, Frederick, Maryland 21702  |                          |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mount Olivet Cemetery, Feb. 19, 1997   |                          | 20c. Location - City or Town, State<br>Frederick, Maryland  |  |
|   | 21. Signature of Funeral Service Licensee<br>Richard E. Prof M00255   |  |  |   | 22. Name and Address of Facility<br>Keeney and Basford P.A. Funeral Home<br>106 East Church St., Frederick, Maryland 21701   |                          |   |  |
|   | 23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Acute pulmonary embolism<br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |   | Approximate Interval Between Onset and Death<br>Minutes  |                          |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                          |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                          |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                          |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M |   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  | 28d. Describe how Injury occurred   |  |                          |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |                          |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  | 29b. Signature and title of certifier<br>Allen J. Gilson MD   |  |                          |   |  |
| 29c. License number<br>D26516   |   |  |  | 29d. Date signed (Month, Day, Year)<br>FEBRUARY 16 1997   |  |                          |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Allen J. Gilson MD 1475 TANEY AVE FRED MD 21702   |   |  |  | 31. Date filed (Month, Day, Year)<br>FEB 18 1997  |  |                          |   |  |
| 32. Registrar's Signature<br>John A. ...  |   |  |  | 33. Registrar's Signature   |  |                          |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06496

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth

Lyle

SMITH

2. Date of Death

February 15, 1997

3. Time of Death

12:50 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

273-46-5273

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

40 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan 11, 1957

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Ijamsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5033-A Mussetter Road

10f. Zip Code

21754

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Pharmaceutical Representative

16b. Kind of Business/Industry

Sales

17. Father's Name (First, Middle, Last)

Horace

E

HENDERSON

18. Mother's Name (First, Middle, Maiden Surname)

Nina

Lyle

PARSONS

19a. Informant's Name/Relationship (Type, Print)

Christopher C. Smith, Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5033-A Mussetter Road, Ijamsville, Maryland 21754

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Smithsburg Crematory Feb 19, 1997 Smithsburg, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

 MO0706

22. Name and Address of Facility

Keeney & Basford P.A. Funeral Home  
106 East Church Street, Frederick, MD 2170123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Methanol Intoxication

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

18 hours

Sequitely list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☒ Could not be  
4 ☐ Homicide determined

28e. Date of Injury

(Month, Day, Year)  
Feb 14, 199728b. Time of  
Injury

6:00p M

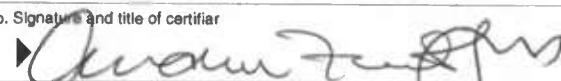
28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject ingested methanol

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)  
At home28f. Location (Street and Number or Rural Route Number,  
City or Town, State)  
5033-A Mussetter Road  
Ijamsville Maryland29e. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D35164

29d. Date signed (Month, Day, Year)

February 19, 1997

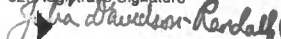
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrew Zarick, Jr., M.D., 1080 W Patrick Street, Frederick, MD 21702

31. Date filed (Month, Day, Year)

FEB 19 1997

32. Registrar's Signature



Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06497

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Cecelia SANTANGELO

2. Date of Death

February 14, 1997

3. Time of Death

8:30 A.M.

4a. Facility Name (If not institution, give street and number)

7424 Picnic Woods Road

4b. City, Town, or Location of Death

Middletown

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

220-26-5332

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 7, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

425 White Oak Place

10f. Zip Code

21703

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

3

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles A. Allen

18. Mother's Name (First, Middle, Maiden Surname)

Etta Huffner

19a. Informant's Name/Relationship (Type, Print)

Michael J. Santangelo, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 677, Middletown, MD 21769

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. John's Cemetery, Feb. 18, 1997 Frederick, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Allan H. Rudy M00703

22. Name and Address of Facility

Keeney & Basford P.A. Funeral Home  
106 East Church Street, Frederick, MD 2170123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CVA Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

6 mos

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Robert L. Kaufmann

29c. License number

D13971

29d. Date signed (Month, Day, Year)

February 14, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Robert L. Kaufmann, M.D., 300 West Ninth Street, Frederick, MD 21701

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

John Davidson Roshell

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06498

## Certificate of Death

Reg. No.

|  |   |                          |   |   |  |   |                                |  |  |  |   |  |   |  |
|--|---|--------------------------|---|---|--|---|--------------------------------|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Evelyn Ruth Shafer                                |                          |   |   | 2. Date of Death<br>Month Day Year<br>Feb. 9, 1997 |   |                                |  | 3. Time of Death<br>10:15 AM                                     |  |   |  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>College View Nursing Center |                          |   |   | 4b. City, Town, or Location of Death<br>Frederick  |   |                                |  | 4c. County of Death<br>Frederick                                 |  |   |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>218-24-1728  |                          | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>Yrs. 78          |   | If Under 1 Year<br>Months Days |  | If Under 24 Hrs.<br>Hours Min.                                   |  | 8. Date of Birth (Month, Day, Year)<br>Oct. 6, 1918 |  | 9. Birthplace (State or Foreign Country)<br>Md. |  |
|  | Usual Residence of Decedent   |                          |   |   |  |   |                                |  |  |  |   |  |   |  |
| 10a. State<br>Md.  |   | 10b. County<br>Frederick |   | 10c. City, Town or Location<br>Burkittsville  |  |   |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |   |  |   |  |
| 10e. Street and Number<br>105 E. Main St.  |   |                          |   | 10f. Zip Code<br>21718  |  |   |                                | 10g. Citizen of What Country?<br>U.S.A.  |  |  |   |  |   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |   |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 Collage (1-4or 5+)   |   |                          |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>homemaker  |  |   |                                | 16b. Kind of Business/Industry<br>own home   |  |  |   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br>Edgar Young Shafer  |   |                          |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ida Ruth Roelkey   |                                |  |  |  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Pat Throne   |   |                          |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>520 North Market St., Frederick, Md. 21701   |                                |  |  |  |   |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |                          |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Union Cemetery  |  | Date<br>2/11  |                                | 20c. Location - City or Town, State<br>Burkittsville, Md.  |  |  |   |  |   |  |
| 21. Signature of Funeral Service Licensee<br>  |   |                          |   |   |  | 22. Name and Address of Facility<br>Donald B. Thompson Funeral Home<br>31 E. Main St., Middletown, Md. 21769  |                                |  |  |  |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |                          |   |   |  |   |                                |  |  |  |   | Approximate Interval Between Onset and Death   |   |  |
| Immediate Cause (Final disease or condition resulting in death)  |   |                          |   |   |  |   |                                |  |  |  |   | months   |   |  |
| Due to (or as a consequence of):   |   |                          |   |   |  |   |                                |  |  |  |   | years  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   |                          |   |   |  |   |                                |  |  |  |   | years  |   |  |
| Due to (or as a consequence of):   |   |                          |   |   |  |   |                                |  |  |  |   |  |   |  |
| Due to (or as a consequence of):   |   |                          |   |   |  |   |                                |  |  |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>previous breast cancer<br>previous colon cancer  |   |                          |   |   |  |   |                                |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                          |   |   |  |   |                                |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                          |   | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |                                |  |  |  |   |  |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   |                          |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No             |  | 28d. Describe how injury occurred              |   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |                          |   | 29b. Signature and title of certifier<br>Kathleen W Stern MD  |  |   |                                | 29c. License number<br>D32073  |  | 29d. Date signed (Month, Day, Year)<br>2/10/97 |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Kathleen W Stern, MD, 610 Ninth Ave, Brunswick, Md. 21716  |   |                          |   |   |  |   |                                |  |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br>FEB 13 1997   |   |                          |   | 32. Registrar's Signature<br>   |  |   |                                |  |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 06499

## Certificate of Death

Reg. No.

|   |   |   |  |  |  |  |  |   |
|---|---|---|--|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Mabel Virginia Strine                     |   |  |  | 2. Date of Death<br>Month Day Year<br>February 8, 1997 |  | 3. Time of Death<br>9:20P.M.   |   |
|   | 4a. Facility Name (If not Institution, give street and number)<br>College View Center |   |  |  | 4b. City, Town, or Location of Death<br>Frederick      |  | 4c. County of Death<br>Frederick   |   |
| Funeral<br>Director   | 5. Social Security Number<br>214-41-1446  |   | 6. Sex<br>1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>94   | If Under 1 Year<br>Months Days                         | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>July 6, 1902  | 9. Birthplace (State or Foreign Country)<br>Maryland  |
|   | Usual Residence of Decedent   |   |  |  |  |  |  |   |
| 10a. State<br>Maryland  |   | 10b. County<br>Frederick  |  | 10c. City, Town or Location<br>Walkersville  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br>49 Frederick Street   |   |   |  | 10f. Zip Code<br>21793   |  | 10g. Citizen of What Country?<br>United States   |  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white                               |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6th College (1-4or 5+)   |   |   |  | 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Retail  |  |  | 16b. Kind of Business/Industry<br>Grocery  |   |
| 17. Father's Name (First, Middle, Last)<br>Blaine Tucker  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lottie Bare   |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>W. Jerome Offutt, attorney  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>22 West Second Street Frederick, Maryland 21701   |  |  |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mt. Hope Cemetery   |  | Date<br>2/11/97  |  | 20c. Location - City or Town, State<br>Woodsboro, Maryland   |  |   |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br>Stauffer Funeral Homes, P.A.<br>1621 Opossumtown Pike Frederick, MD 21702  |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <u>CVA</u><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |   |  |  |  |  |  | Approximate interval Between Onset and Death<br>1 mo. |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |
|   |   |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |
|   |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28e. Date of Injury (Month, Day Year)   |  | 28b. Time of injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                     |
|   |   | 28e. Place of injury - At home, term, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   | 29b. Signature and title of certifier<br>   |  |  |  |  |  |   |
|   |   | 29c. License number<br>D13971   |  | 29d. Date signed (Month, Day, Year)<br>2-10-97   |  |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. Robert L. Kaufmann Frederick, Maryland  |   |   |  |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br>FEB 10 1997  |   | 32. Registrar's Signature<br>   |  |  |  |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 06500

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charlotte Estelle Sample

2. Date of Death

February 18, 1997

3. Time of Death

11:52 A.M.

4a. Facility Name (If not institution, give street and number)

Rockville Nursing Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

224-60-5898

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 30, 1920

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

118 Monroe Street, #702

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Harry Paul Sample

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Clare Hission

19a. Informant's Name/Relationship (Type, Print)

Richard J. Sample / Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

118 Monroe Street, #702, Rockville, Maryland 20850

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)February 19, 1997  
Montgomery Crematorium, Inc.

Date

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Michael P. Kutta M00348

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/  
Rockville, Inc., 300 W. Montgomery Avenue,  
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Parkinson's Disease

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

David A. Hudhud, M.D.

29c. License number

D41866

29d. Date signed (Month, Day, Year)

February 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David A. Hudhud, M.D. 481 North Frederick Avenue #230 Gaithersburg, Maryland

31. Date filed (Month, Day, Year)

FEB 20 1997

32. Registrar's Signature

John Davidson-Rodriguez

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
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/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
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certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

